Faculty of Medicine University of Toronto

Dean's Midterm Report

1984

Digitized by the Internet Archive
in 2018 with funding from
University of Toronto

https://archive.org/details/midtermreport1984facu

F 016 031

Faculty of Medicine
University of Toronto
Office of the Dean

9 July 1984

Dear Colleague,

In recent years the Faculty of Medicine and its affiliated teaching hospitals have undergone major development, as the University of Toronto Health Science Complex has assumed national leadership in many areas.

Since adequate communication frequently is a problem in this diverse and dispersed Health Science Complex, I thought it would be helpful to present a "state of the union" review of one of its major components - the Faculty of Medicine. The mid-point of my seven year term as Dean has just passed, and it seemed appropriate to use my mid-term report as a vehicle for this review. The report was presented to the Faculty of Medicine Council on March 26, 1984; I now submit it to you for your information.

Many members of my staff and colleagues assisted in the preparation of this report, and I am most grateful to them. I wish to acknowledge with thanks the generous contribution of John W. Browne, and the special help of Terry Fearman, Sherril Gelmon, James Kraemer, Elizabeth Scott, Teresa Cromwell, and Liivi Currier and her staff.

Together with my colleagues throughout the Health Science Complex, I look forward to the next few years. Despite the tight budgeting constraints that are still with us, there is every reason to believe that our forward progress will not slow down.

Yours sincerely,

Fred Lowy

Frederick H. Lowy, M.D.,

FHL/k

Medical Sciences Building
Toronto, Ontario, M5S 1A8
(416) 978-2710

TABLE OF CONTENTS

Page

I. INTRODUCTION 1

II. DEVELOPMENTS — 1980-83 2
1. EDUCATION 2
a) Undergraduate Medical Program 2
b) Other Undergraduate Programs 3
c) Graduate Studies 3
d) Postgraduate Medical Programs 4
2. RESEARCH 5
3. FACULTY ORGANIZATION 6
a) Dean's Office 6
b) New Chairmen 6
c) Planning Mechanisms 7
d) New Structures 8
e) Budget and Personnel 8
4. FACULTY — UNIVERSITY RELATIONS 9
a) Reporting Relationships 9
b) Personnel Issues 9
c) Fund Raising 10
d) Tenure Pool and Long Range Planning 10
5. FACULTY — HOSPITAL RELATIONS:
THE UNIVERSITY OF TORONTO HEALTH SCIENCE COMPLEX 10

III. STATE OF THE FACULTY — 1984 12
1. ACCREDITATION SITE VISITS 12
2. THE STRATEGIC CHALLENGE 12

IV. PLANS AND PRIORITIES — 1984-87 14
1. BASIC SCIENCE DIVISION 14
2. COMMUNITY HEALTH DIVISION 14
3. CLINICAL DEPARTMENTS 15
4. PRIORITIES FOR THE FUTURE 15
5. ORGANIZATION OF THE DEAN'S OFFICE (1984-87) 16

V. SUMMARY AND CONCLUSION 17

REFERENCES 18
APPENDIX — Department Chairmen 1980-84

I. INTRODUCTION

The University of Toronto's Faculty of Medicine is the largest and one of the oldest medical schools in Canada. Until the opening of the University of King's College medical school in 1843, medical education was sporadic and was conducted privately in Upper Canada, although plans for a medical faculty had been discussed since 1827 when the College was being organized. In 1843 also, Dr. John Rolph's Toronto School of Medicine was founded.

From 1843 until 1906, when the University of Toronto Faculty of Medicine became the only medical school in the city, five separate institutions offered medical instruction, though not all simultaneously. They included, in addition to those mentioned, the Medical Department of Victoria College, the Medical Faculty of Trinity College, and the Ontario Medical College for Women. This latter school was set up in 1883 to provide medical education for women until the University of Toronto agreed to do so in 1906, after which its existence was no longer required.

During the past 140 years, a number of buildings have been occupied by the Faculty and by the scientists, teachers and clinicians who gave it its reputation, culminating with the construction of the Medical Sciences Building in 1966.

The present size and configuration of the Faculty owe much to a major planning exercise which took place in the late 1960's, which is summarized in the *Report of the Independent Planning Committee*.[1] This Committee, established by Faculty Council, was charged by the Ontario Ministers of Health, Education, and University Affairs to make recommendations about the requirements to 1975 for teaching and research facilities in the Toronto hospital network.

The *Report* stated in detail the complement changes required to deal with the request by the provincial government to increase medical undergraduate enrolment from 700 to 1,000 students, the need for a hospital teaching network, and the major responsibilities borne by the University of Toronto in health sciences education. It outlined a role for Sunnybrook Hospital as a general hospital stressing family practice, established standards for the accommodation of chairmen and geographical full-time appointees in the teaching hospitals, and called for new income and appointment policies in order to ensure equity throughout the system.

One of the key statements in the *Report* set the tone for developments in Toronto which are now coming to full fruition, twelve years later. "Insofar as their educational function is concerned, the teaching hospitals and the Faculty of Medicine are, in a sense, but one institution — a school for the instruction of undergraduate and postgraduate medical students in the interests and for the welfare of the people of Ontario." (*Report*, page 155.)

This statement prefigures the growing interdependence between the hospitals and the Faculty which has resulted in an increasingly integrated Health Sciences Complex.

A second important document, the *Report of the Institutional Self-Study Steering Committee*[2], was prepared by the Faculty as part of the 1977 LCME/CACMS Accreditation Site Visit and, coming as it did at the end of the period covered by the *Independent Planning Committee Report*, initiated another cycle of planning. The Self-Study Committee stated objectives for the Faculty, and identified the strengths and weaknesses of various programs. While it was not, in itself, a planning document, it provided the basis for the Faculty's submission to the University's Planning and Priorities Sub-committee in August, 1977. Although the final report of that sub-committee ranked nine Faculty objectives, a much longer original list was submitted to the University's central administration.

Exhibit 1
Faculty of Medicine Objectives, 1976

1. The selection, education and training of students to be competent and ethical health professionals.
2. The selection and training of competent researchers and scholars in scientific and applied fields.
3. The training of teachers for the health disciplines.
4. To act as consultants to governments, hospitals and other institutions and agencies.
5. To provide continuing education of health professionals.
6. Through its educational and research programs, to assist its affiliated institutions in the delivery of exemplary health care to the ambient community.
7. To effect through its related health care delivery settings, model programs in health care and health maintenance.
8. To aid in the education of the public in matters of health.
9. To undertake research and experimentation designed to improve the quality of the teaching-learning experience.
10. To provide, through its own and its affiliated facilities, settings and opportunities for research, the ultimate goal of which is the improvement of the quality of life of our citizens.

This list has guided much of the Faculty development since then, and we now have completed most of the tasks it enumerated. Our success in accomplishing these by the beginning of the decade, together with the chance to appoint new Chairmen for most of the Departments, offered us a unique chance for renewal and redirection in the 1980's. This *Dean's Mid-term Report* should be viewed, then, in the light of these earlier documents.

TABLE 1
UNIVERSITY OF TORONTO
MEDICAL GRADUATES
PASS RATE — LMCC EXAMINATIONS

Year	No. of Graduates	LMCC Exam Failures	Pass Rate (to nearest percentage point)
1974	230	4	98%
1975	237	1	99%
1976	240	5	98%
1977	245	2	99%
1978	245	4	98%
1979	256	6	98%
1980	242	2	99%
1981	253	5	98%
1982	245	5	98%
1983	243	7	97%

TABLE 2
UNDERGRADUATE MEDICINE:
GRADE POINT AVERAGES
OF ENTERING CLASSES

Year	GPA (out of 4.00)
1983/84	3.68
1982/83	3.67
1981/82	3.70
1980/81	3.68
1979/80	3.65
1978/79	3.65
1977/78	3.67
1976/77	3.64
1975/76	3.70
1974/75	3.70

II. DEVELOPMENTS 1980-1983

On assuming the position of Dean of Medicine on July 1, 1980, I found the Faculty basically healthy and strong, the result of effective leadership by Dr. R.B. Holmes and his predecessors, and the dedication of our faculty. By then, the Faculty was responsible for teaching 1,000 medical undergraduate students, 1,450 interns and residents, 2,500 undergraduate students registered in the Faculty of Arts and Science, 350 undergraduate students in allied health programs, and over 400 graduate students registered in the School of Graduate Studies. The research funding for the Faculty represented almost half of the research income flowing through the University.

Clearly, during the decade of the 1970's, Toronto had become the unchallenged leader of Canadian academic medicine. Many of our departments were the best in Canada and, in several others, Toronto's potential was widely acknowledged, always with the implication that the absence of national primacy was a correctable aberration. Particularly in the clinical disciplines, much of Canada looked to the University of Toronto for leadership and opportunities for sub-specialty training, some of which were unavailable in many parts of the country. In addition, a few of our programs were clearly of international stature.

Needless to say, I felt privileged to be selected as Dean of this prestigious faculty, the second psychiatrist (after C.K. Clarke, 1908 to 1920) to be granted this honour.

Nevertheless, in 1980 it was not difficult to recognize at least six major challenges that confronted the Faculty:

1. Reviewing the undergraduate medical curriculum which was being subjected to increasing criticism;
2. Strengthening the network of teaching hospitals, their relationship with the University, and their commitment to education and research;
3. Replacing chairmen and directors whose terms expired in 1980 and 1981;
4. Absorbing five years of successive base budget cuts with the prospect of further reductions ahead;
5. Defining more closely the mission of the Faculty, priorizing its objectives, and instituting planning processes to achieve these, despite budget cuts; and
6. Consolidating the organization of the Dean's Office which had been initiated in 1979.

Each of these challenges will be considered in detail in subsequent sections of this report.

1. EDUCATION

a) Undergraduate Medical Program

Both the entry level marks and the results of Medical Council of Canada examinations demonstrate that the Faculty attracts outstanding students who can successfully master the undergraduate medical program. Last year's success rate on the LMCC was 97%, and the entry level for students admitted in September, 1983 was a 3.68 Grade Point Average. On both of these measures, we are usually among the leaders in Canada; they have remained virtually unchanged over the past several years, as illustrated in Tables 1 and 2.

Until the late 1960's, Toronto had a traditional, department-oriented undergraduate curriculum. The increase in the size of the medical undergraduate class and the move to the new Medical Sciences Building were accompanied by a major change to systems teaching which itself has undergone some modification in the last decade. The changing character and interests of the students, as well as some of the structural problems inherent in systems teaching, led to criticisms of the curriculum in the late 1970's.

One of the deficiencies was dealt with by the students themselves when they introducted a voluntary course on biomedical ethics. Other criticisms had more to do with the structure of the curriculum as a whole. Students felt that the curriculum was too highly structured and was oriented more to factual transfer than to knowledge integration and problem solving. In the recent LCME/CACMS site visit, the students expressed their feeling that the expectations of some teachers were unrealistic; for example, they pointed out to the review team that "several of the undergraduate course syllabi were highly sought after by *final year specialty residents* due to the depth and detail of information included".[3]

The curriculum now is again in the process of renewal. This should not be surprising since, in some ways, the expectations of patients, the health care system, society at large, teachers and students change. As a result of intensive work during 1982 and 1983, a Task Force chaired by Dr. E.M. Sellers, Assistant Dean — Undergraduate Medical Curriculum, recommended to Faculty Council in October 1983 that the curriculum be altered to:

- increase appreciation of psychological and sociocultural factors in disease and illness behaviour,
- increase awareness among medical undergraduates of community needs and resources,
- reintroduce the study of basic biological sciences in the Third Year,
- reduce detail overload generally,
- reduce curricular contributions to student stress, and
- introduce new courses such as critical appraisal of decision-making and information.

The successful student-initiated elective in biomedical ethics grew into a core course in medical humanities.

Despite the clearly superior intellectual level of our medical students, the question is often asked whether they always are best suited to practice the kind of medicine that society expects, i.e. a more personal, more humane, less technology-oriented medicine which at the same time is informed by scientific advances. At the extreme, critics contend that today's medical students are not well suited to do this; in *TIME Magazine*, recently, U.S. medical students were characterized as "aggressive, competitive, narrow, dishonest, unfriendly individuals — in other words, nerds."[4] I believe that very few indeed of our students fit this caricature. Nevertheless, our Undergraduate Medical Admissions Committee is looking at several ways by which premedical students can be encouraged to broaden their educational experience beyond the courses that facilitate admission to medical school.

EXHIBIT 1

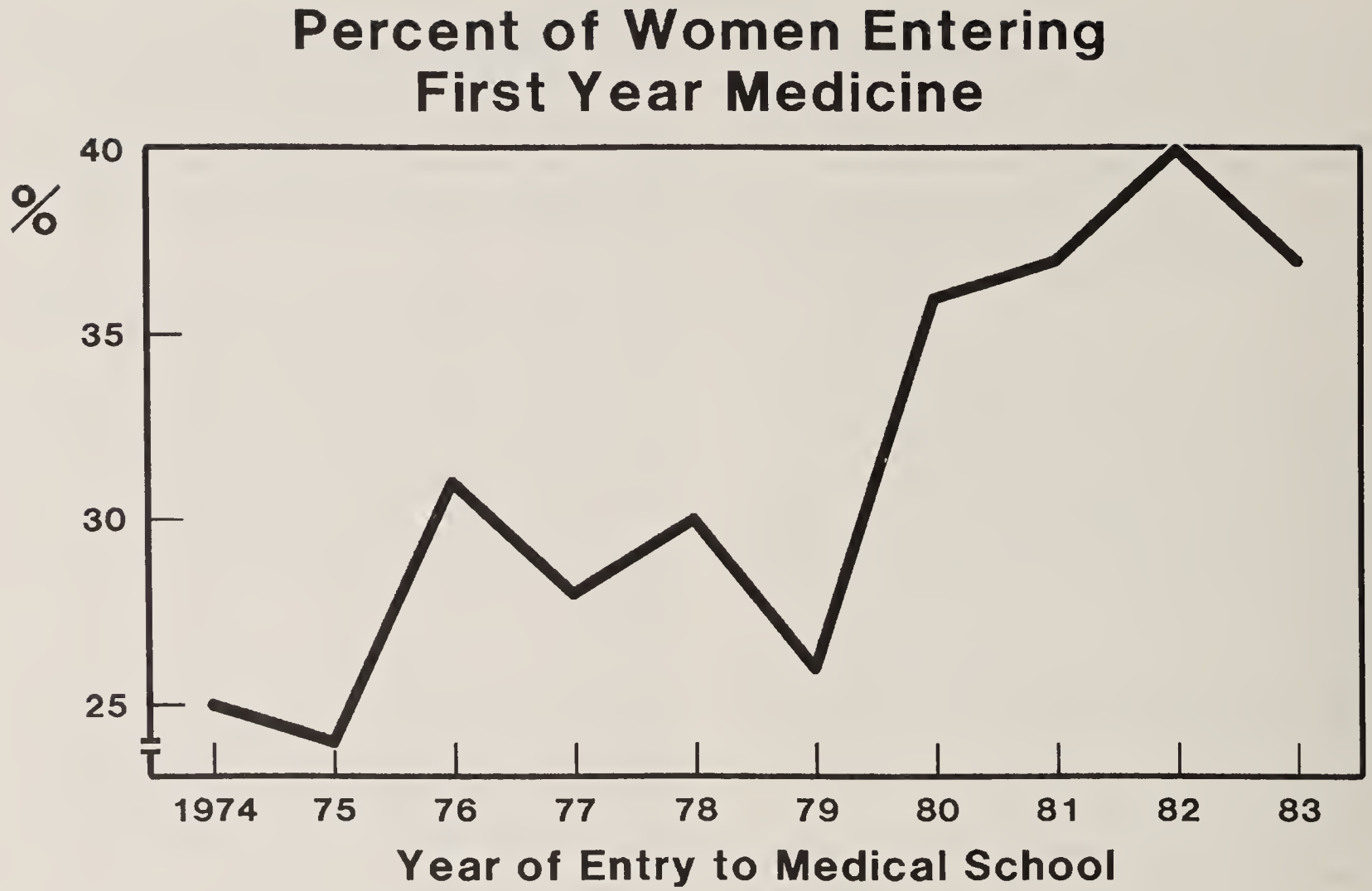


TABLE 3

UNIVERSITY OF TORONTO, FACULTY OF MEDICINE
GRADUATE (S.G.S.) ENROLMENT: 1979-83

	PhD		MSc		MHSc		Special Students		Total	
	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time	Full Time	Part Time
1979/80	143	26	156	57	160	5	8	28	467	116
1980/81	166	24	167	49	155	12	7	33	495	118
1981/82	180	22	206	63	160	10	11	28	557	123
1982/83	217	16	211	66	171	17	16	33	615	132
1983/84	242	24	260	49	181	35	10	32	693	140

The percentage of women entering the first year medical class has been rising, from 25% in 1974 to the 36 to 40% levels of the past four years (see Exhibit 1, opposite). This is especially noteworthy this year, which is the 100th anniversary of the graduation of the first woman physician in Toronto, Dr. Augusta Stowe-Gullen. Before 1884, many qualified women, including her mother, Dr. Emily Stowe, were refused admission to medical schools on the basis of gender.

The 1983 CACMS-LCME Accreditation visit revealed again that some of the students believe that our course is overly stressful. To examine whether, in fact, our students are subject to undue or unnecessary stress, I have set up a broadly representative Task Force on Student Stress under the chairmanship of Dr. E.L. Lansdown, to examine this issue in detail. We await their report in due course.

All in all, there is good reason to believe that our medical undergraduate course is excellent, and is among the best in North America. Credit for this is due not only to Drs. W. H. Francombe and E. Llewellyn-Thomas, who for many years have directed curriculum and student affairs, and Dr. E.M. Sellers who joined them more recently, but also to the hundreds of teachers, many of them volunteers, who have recognized that educating medical students is one of the greatest privileges that Faculty status confers.

b) Other Undergraduate Programs

The Faculty is responsible for two other undergraduate programs — in Art as Applied to Medicine, and in Physical and Occupational Therapy.

The Bachelor of Science program in Art as Applied to Medicine is unique in Canada in that it is the only degree-granting program of its kind. The program lasts three years, and now enrols five students per academic session for a total program enrolment of fifteen students. The Department teaches a large number of special part-time students.

Graduates of this program are much sought after as medical illustrators in universities, hospitals and industry. This program is not well known to all members of the Faculty, but it is of high quality and a source of pride for us. Although it has been protected from budget cuts to a large extent over the past few years, this program's small funding base has suffered some erosion. This and the forthcoming retirement, in 1985, of Professor N. Joy, Chairperson and Program Director, will require a careful examination of its funding needs and organization.

The Bachelor of Science programs in Physical Therapy and Occupational Therapy together enrol just over three hundred students, slightly over 20% of the total undergraduate enrolment in the Faculty. Since 1979-80, the enrolment in these programs has been relatively stable, although there has been an increase of approximately twenty students in the past five years. Approximately 60% of the students enrol in the Physical Therapy program and 40% in the Occupational Therapy program.

These undergraduate programs produce a substantial proportion of the total Canadian output in their professions each year. Indeed, we are responsible for training many of Ontario's physiotherapists each year and almost half of the occupational therapists.

The students attracted to the B.Sc. (O.T.) and the B.Sc. (P.T.) programs are of extremely high calibre; as with entry to the undergraduate medical program, competition for available places is keen.

During the past year and a half, the Department of Rehabilitation Medicine — which has been the administrative home for these programs — has been under close review by the Dean's Office and a number of options for its future have been considered. Staff and students have urged very strongly that both programs remain in the Faculty of Medicine, despite the fact that their development has not been a high priority for the Faculty in the past. It cannot be denied that they have not always had the attention they deserve because of the pressures of operating very large undergraduate and postgraduate medical programs.

During the past several months the Associate Dean — Clinical and Institutional Affairs has himself acted as Chairman of the Department of Rehabilitation Medicine and has proposed a plan for the future development of the Department. It has now been demonstrated that the concept of a three division, multidiscipline department devoted to education and research in the area of the readaptation of disabled persons is viable, and that the department can mount programs of good quality even within the context of the Faculty's budgetary constraints.

As a result of actions taken in the Dean's Office last year, the Divisions of Physical Therapy and Occupational Therapy have begun a curriculum renewal program which is as intensive as that now underway for the medical program. Many of the same issues are being debated: the need to consider the social responsibilities of physical and occupational therapists, the appropriate curricular blend of clinical and basic science, the incorporation of new advances into the curriculum, and the need for students to learn techniques of critical appraisal. The initiatives of members of these two divisions are most welcome and I encourage them in their planning efforts.

c) Graduate Studies

The Faculty is responsible for operating graduate degree programs at the M.H.Sc., M.Sc. and Ph.D. levels which are under the academic control of the School of Graduate Studies. In fact, thirteen of the twenty departments in Division IV, the Life Sciences, draw all their resources from the Faculty and its teaching hospitals.

According to recent data available from the School of Graduate Studies, graduate student enrolment in programs supported by the Faculty (special student, M.H.Sc., M.Sc., Ph.D.) has grown from 583 individuals in 1979-80 to 833 students in 1983-84, an increase of almost 43% (see Table 3). Enrolment in doctoral programs has increased the most, growing by almost 57% over that time period. Enrolment in MSc programs has increased by 45%. The largest programatic increase is not reflected in Table 1 because it occurred in the late 1970's when a series of professional programs leading to the degree of Master of Health Sciences was developed in the Graduate Departments of Speech Pathology and Community Health. Among them, these programs now enrol 216 full-time and part-time students, or 25% of the total graduate enrolment of the Faculty of Medicine departments. These enrolment trends are depicted in Exhibit 2.

As you will see from an analysis of budget and personnel later in this report, this increase in graduate enrolment has occurred without a corresponding increase in base budget supported full-time academic staff. In other words, we are now teaching 250 more graduate degree candidates than we were in 1979-80, with the same number of University-supported Faculty members. No doubt, increased enrolment in graduate degree programs has been supported partially by increases in grant-supported

EXHIBIT 2

GRADUATE (S.G.S.) ENROLMENT TRENDS

Cumulative totals

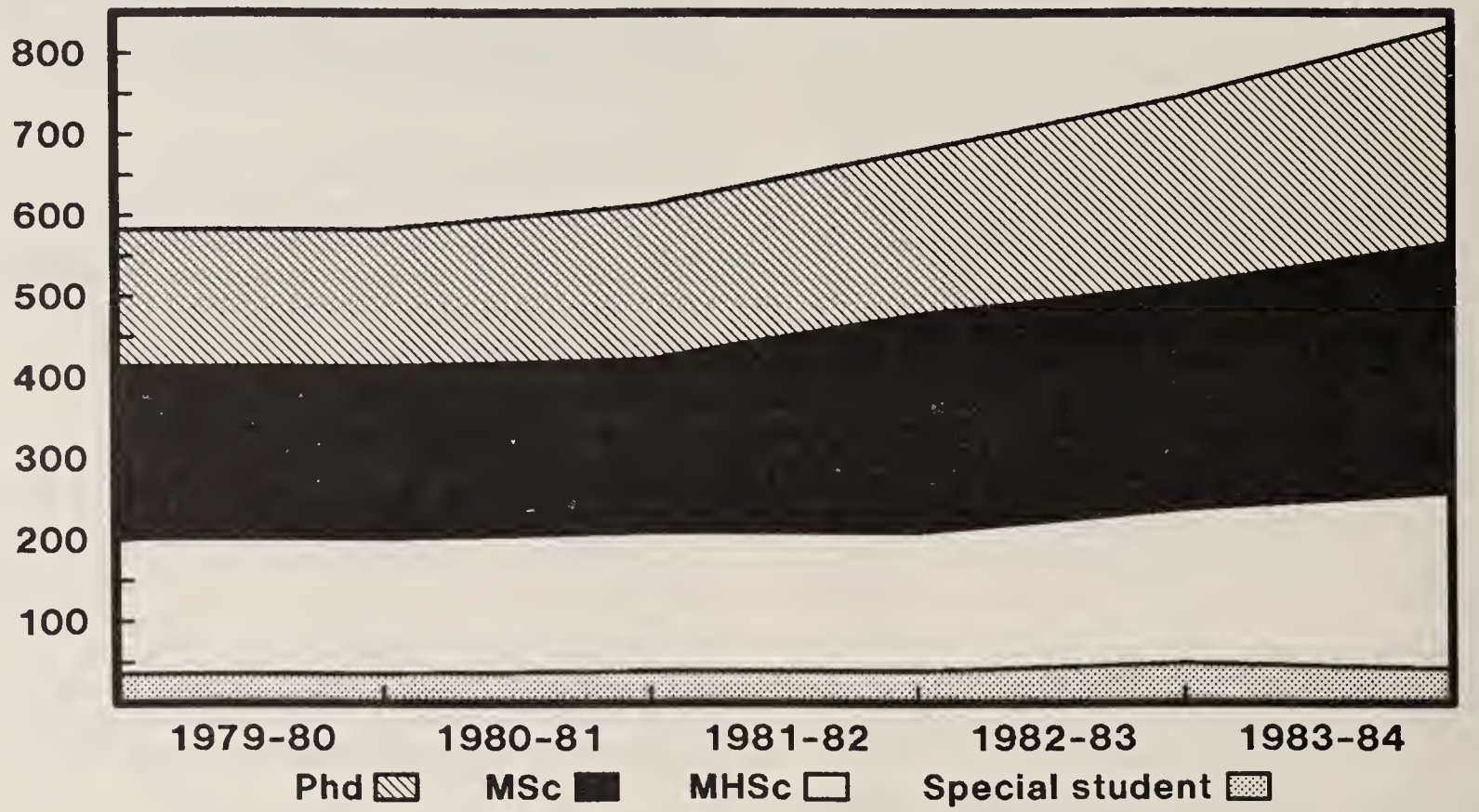
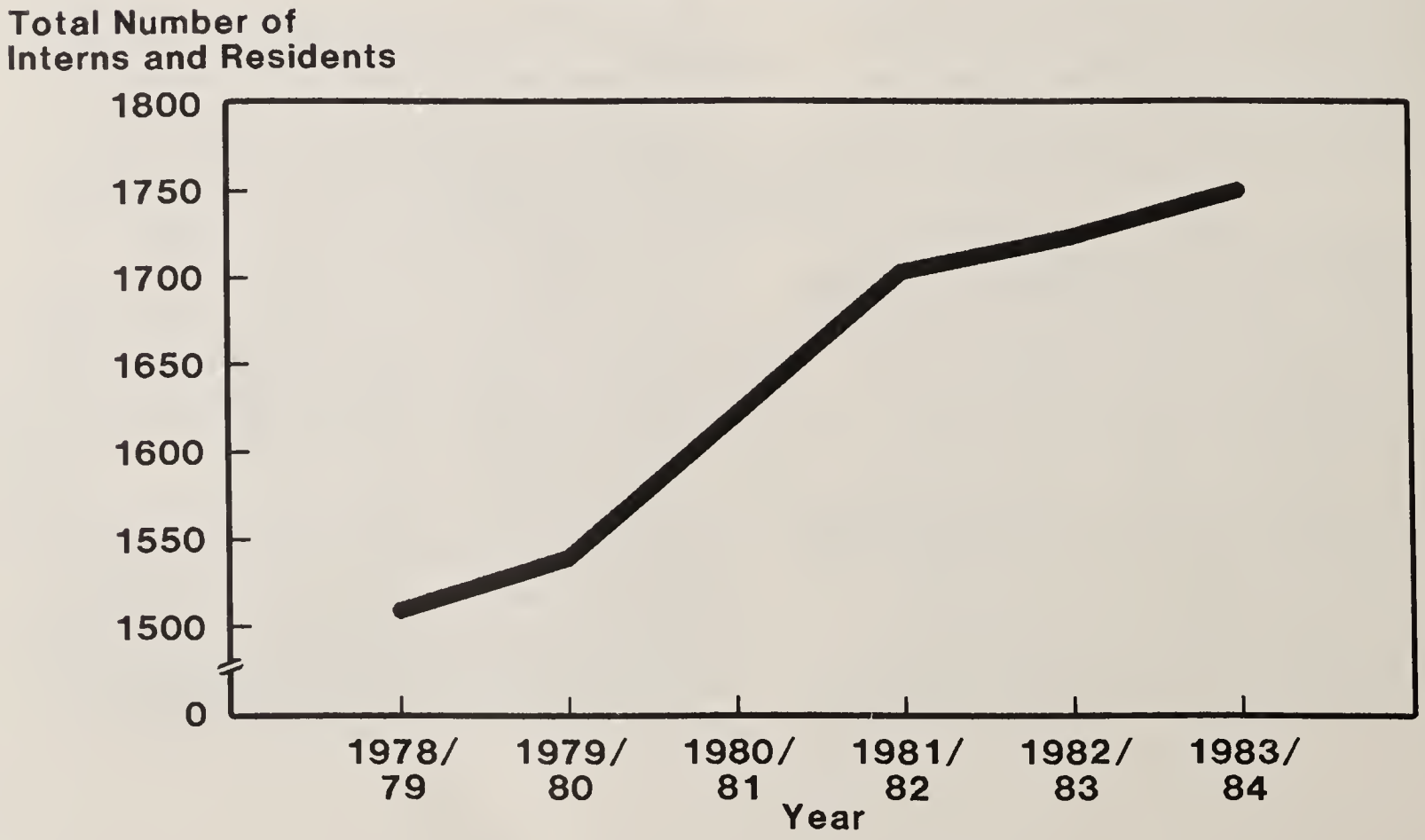


EXHIBIT 3

Post-Graduate Enrolment Trends 1978 - 1983



academic staff. Nevertheless, the University has reaped the benefits of additional formula income and the maintenance of prestigious — in some cases world-class — programs without a corresponding increase in base budget support. The recent survey of Life Science programs by the Ontario Council of Graduate Studies indicates that their quality has not yet been diluted, but I suspect we soon may reach the point where any further increases in enrolment will jeopardize our excellence unless they are matched by base budget increases.

Growth in graduate degree programs has also increased the pressure for space and resources, largely in the basic science and community health departments. Recent changes to the undergraduate program regulations in the University — "The Kelly Rules" — have added additional responsibilities to the basic science departments which teach in the Faculty of Arts & Science. No accurate data are available about increased undergraduate loads, but it is clear that many basic science departments have increased their full course equivalents over the past two years. Although many departments welcome the new undergraduate program requirements from the point of view of developing future scientists and scholars, it cannot be denied that we are working harder and that our resources will soon be strained to the limit.

d) Post-Graduate Medical Programs

This Faculty is responsible for the largest, most diverse and in many disciplines the best postgraduate programs in Canada. During the past three years, under the leadership of Dr. R. H. Sheppard, Associate Dean — Postgraduate Affairs, there have been major changes in the organization of the internship and residency programs. The basic theme has been an accelerated evolution from what was once a fragmented, hospital-based group of programs to a centrally coordinated University program in virtually all departments and their divisions. This has been supported by an administrative structure designed to ensure quality control, communication and coordination among hospitals and disciplines, and accountability both to the accrediting bodies — the Royal College of Physicians and Surgeons and the College of Family Physicians of Canada — and the Ministry of Health.

The central coordinating body is the Postgraduate Medical Education Committee of Faculty Council, which has been strengthened greatly in recent years. Its Rotating and Mixed Internship Committee has centralized the administration and quality control of the rotating and mixed internship programs. In 1978, six new hospital-based programs in community hospitals were integrated with the six already in the network into a single University training program. In 1983, a thirteenth hospital, York-Finch Hospital, was added to the network. The eleven fully affiliated teaching hospitals and over 20 partially affiliated hospitals participate in 43 University specialty residency programs and nine subspecialty programs.

All of this has been associated with the development of guidelines dealing with standards of excellence related to admissions procedures, curriculum development, program flexibility and evaluation techniques. The latter involves not only up-graded mechanisms for the evaluation of trainee performance, but also the development of a careful survey process which scrutinizes each program at regular intervals and which leads to appropriate recommendations. At all levels, participation by the interns and residents has been included.

Associated with these organizational developments has been a steady increase in the number of postgraduate students; this has reached a plateau during the last year only because of provincial government restrictions. Still, the total number of postgraduate trainees has grown from 1517 in 1978 to close to 1761 in 1983 (as shown in Exhibit 3, opposite, and Table 4, overpage). Most impressive has been the development of excellent new programs in Geriatric Medicine, Emergency Medicine, Clinical Pharmacology, Paediatric Cardiology, Psychogeriatrics, Tropical Medicine, Critical Care and Neonatology. In addition, it is fair to say that the breadth and depth of the training experience in most of our postgraduate programs have increased substantially.

In March 1983, our postgraduate programs were reviewed by a twenty-three person team from the Royal College of Physicians and Surgeons of Canada. Forty-eight specialty programs were approved unconditionally, often with high praise. The three programs that were approved conditionally were resurveyed in the spring of 1984; we have good reason to believe that full approval will be granted now that corrective measures have been applied. The accrediting team concluded that "the overall quality of training programs in the University of Toronto is high and some of the programs, the best in Canada, have a well deserved international recognition. The overall quality of teaching and resident staff is high."[5]

A further development over the last few years has been a steady improvement in the relationships with other Canadian medical schools, particularly through the Council of Ontario Faculties of Medicine (COFM) and its Postgraduate Education Committee, and the Association of Canadian Medical Colleges. This has led to considerable cooperation among representatives from the different schools to the advantage of all.

The development of a central payroll system for funding of Ministry of Health supported postgraduate trainees, as well as many others, occurred in 1979 and did much to facilitate centralization of postgraduate administration. Also, the Ontario Manpower Data Centre, for which our Faculty provides staff and housing in close proximity to the Postgraduate Education Offices, has worked closely with this office. This cooperative association has been of great assistance in providing a clearer picture of the postgraduate establishment.

Although the postgraduate medical programs are a major source of pride for the Faculty and one of the reasons for its excellent reputation, they also have been the source of considerable controversy among our clinical departments and teaching hospitals. All of these, understandably, are highly protective of their portions of the residency programs and wish to see them grow and develop to the limits of educational capacity. Our ability to attract high quality residents and to develop first class programs for them in hospitals with facilities mostly unsurpassed in Canada has resulted in a 16% increase in postgraduate students in the past five years, a time when many residency programs in Canada and the United States underwent decline. Our fully subscribed and growing programs therefore were affected especially by Ontario government restrictions on Ministry of Health funded positions and their subsequent freeze on total postgraduate positions. In accordance with a 1982 agreement between the Ministry of Health and COFM, the government did not cut MOH funded positions further in 1983 and 1984 in return for a temporary freeze on growth of the total number of positions and a reallocation of some posts to underserviced specialities.

This has dictated some cut-backs in the assignment of residents to various hospitals and to some of our most popular programs. We have attempted to determine priorities for each discipline for the various teaching hospitals in an orderly fashion and to assign residents accordingly. The mechanism for doing this involves the departments, the teaching hospitals and the Postgraduate Medical Education Committee. In summary, major advances have occurred in the postgraduate medical programs to the benefit of the interns and residents and the clinical departments.

TABLE 4

POST-GRADUATE STUDENTS FACULTY OF MEDICINE, 1978-1983

Year	Interns	Residents	Total	Ministry of Health Funded	
				#	%
1978-79	350	1159	1509	1311	86.9
1979-80	367	1172	1539	1312	85.3
1980-81	375	1245	1620	1296	80.0
1981-82	389	1314	1703	1289	75.7
1982-83	382	1341	1723	1260	73.1
1983-84	404	1346	1750	1265	72.3

TABLE 5

MRC FELLOWSHIPS BY PLACE OF TENURE

University	1980-81	1981-82	1982-83
Alberta	9	4	4
U.B.C.	12	16	13
Calgary	6	3	2
Dalhousie	2	6	5
Guelph	13	13	12
Laval	7	5	4
Manitoba	14	14	13
McGill	40	34	34
McMaster	5	9	10
Memorial	1	2	-
Montreal	16	13	12
Ottawa	3	4	11
Queen's	3	5	6
Saskatchewan	5	3	6
Sherbrooke	3	3	2
Toronto	**62**	**61**	**72**
Western	8	10	8
Other	137	123	120
TOTAL	342	328	334

Source: Office of Research Administration, September 1983.

2. RESEARCH

The University of Toronto Health Science Complex leads all Canadian academic centres with respect to funding for health-related research. In 1982-83, members of this Faculty received more than $50 million of external grant support: $33,630,000 was administered directly through the University, and almost $20 million through the teaching hospitals. By comparison, the rest of the University of Toronto received $48,140,000 in external research funds. Medical Research Council awards to Toronto by far outdistanced awards to McGill University, which has been in second place in recent years. We do even better in competition for research funds awarded by other national health agencies.

The Faculty mission statement, which I will discuss later, clearly priorizes research and the creation of new knowledge, which I believe is essential if we are to maintain our position in the first-rank of medical schools in Canada.

The size and number of research units in our Health Science Centre creates enormous diversity of opportunity. I couldn't help thinking that the recent discovery by Dr. Tak Mak (Department of Biophysics and the Ontario Cancer Institute) of the gene which codes for the T-lymphocyte receptor illustrates an important characteristic of science and the value of our diversity. While at the OCI, Dr. Mak entered this area in a collaborative effort, with investigators at the Hospital for Sick Children, to clone the gene for the enzyme adenosine deaminase, which is associated with a form of T-cell deficiency. While carrying out this work, he made observations which this year led him and his team to isolate the gene for the T-cell receptor, the fundamental recognition unit of the immune system. I venture to say that his chances of making this discovery would have been smaller without the diverse research programs we have here. It also illustrates the synergism arising from co-operative interaction.

The most important research development during the past three years has been the establishment of general hospital research institutes, with a commitment of resources to both basic and clinical research. Although the specialty hospitals (Hospital for Sick Children, Princess Margaret Hospital — Ontario Cancer Institute, Clarke Institute of Psychiatry, Addiction Research Foundation) have always had specific research mandates, and clinical research has taken place in all teaching hospitals, it is the establishment of formal research institutes in the large general teaching hospitals that is new.

While these developments initially began without much central faculty coordination, there is now considerable formal collaboration between the Faculty and the hospitals (Hospital-University Research Co-ordinating Committee, Health Sciences Complex Management Advisory Committee). A policy of joint recruitment and appointment of new scientists in hospitals, which is close to being completed, will help in creating a collaborative vision for future research thrusts. Shared services such as animal facilities are being planned to ensure that unnecessary duplication is avoided. In some instances, the animal facilities likely will be operated jointly by several hospitals and the Faculty. The Faculty has applied recently to the McLaughlin Foundation for funds to promote this interaction, by adding funds flowing through the University to hospital-derived funds for basic scientists in the new research institutes. It is essential for the Faculty's long-term goals to ensure close interaction between our two campuses.

The main problems which face us in the research area are:

1. developing flexibility within our compressed university budget to support a stronger research infrastructure;
2. developing further our funding from external sources;
3. improving our "capture rate" for research grants in some departments;
4. helping some of our departments to shift their major foci of activity to research at the cutting edge of their fields;
5. making more high quality research space available by renovating laboratories in the FitzGerald Building and the Banting Institute, and developing a more flexible space policy for the MSB.

Furthermore, central University administration support to replace our retiring faculty will depend on our ability to articulate clearly a credible research plan for the future. The Basic Science chairmen recently embarked on a joint planning initiative in which multidepartmental coordinated appointments and space allocation are being explored.

I should point out that although we rank first as a faculty in capturing available Canadian research dollars, we do not do as well if we look at national research funds awarded by individual grantee. In 1981-82 (the last year for which we have accurate figures), we ranked only ninth in awards per grantee from the MRC (compared with the leader, McGill, seven other universities and the national average). We did better (fourth) when all health agencies were compared; here we exceeded the national average and were led only by Alberta, Calgary and Sherbrooke, universities that received considerable provincial support. However, the relatively low rank in MRC funding by grantee makes one wonder whether we have fewer stars shining at the frontiers of research than we ought to have. We have also failed to reach our potential with respect to capturing MRC studentships. To be sure, we have done well in the number of MRC fellowships during the past three years (as illustrated in Table 5, opposite).

Tenured appointments are clearly one of our most valued research resources and it is the responsibility of us all to ensure that the very best people with the most relevant skills are hired to fill available vacancies. We must develop policies which allow us to hire excellent people who become available even when the particular department that the individual would normally go to does not have an available tenure slot. The corollary is that we all must be willing to share in the service and teaching needs of a department when no excellent applicant for an available tenure slot is available. The appointment of only truly excellent poeple is the major way we can ensure future research excellence here in Toronto.

In addition, the infrastructure must be strengthened to provide support for our investigators. Funds available for starting new projects, bridging new appointments and support of post-doctoral fellows are well below the level they should be. We are planning to explore opportunities for Faculty fund-raising to develop stronger support for each of these areas. We must also be more aggressive in securing support from the private sector for joint University-industry collaboration. Dr. Underdown informs me that despite encouragement from his office to investigators to go after the funds available in the new government-sponsored PILP (Program for Industry/Laboratory Projects) program, the major Faculty initiatives (leading to the capture of approximately a half million dollars of extra funding) came largely from the immunologists, where he himself put the available knowledge to good use. Chairmen must consider it among their responsibilities to stimulate their colleagues to expand their funding bases.

There are other areas in which we clearly need to improve. Although official results of the current year's competition for MRC scholarships are not yet available, it seems that we did not do well at all; very likely we did not put the best people forward in this competition. On the brighter side, we specifically identified some

EXHIBIT 4

Organization of the Dean's Office Faculty of Medicine, 1980 - 1984

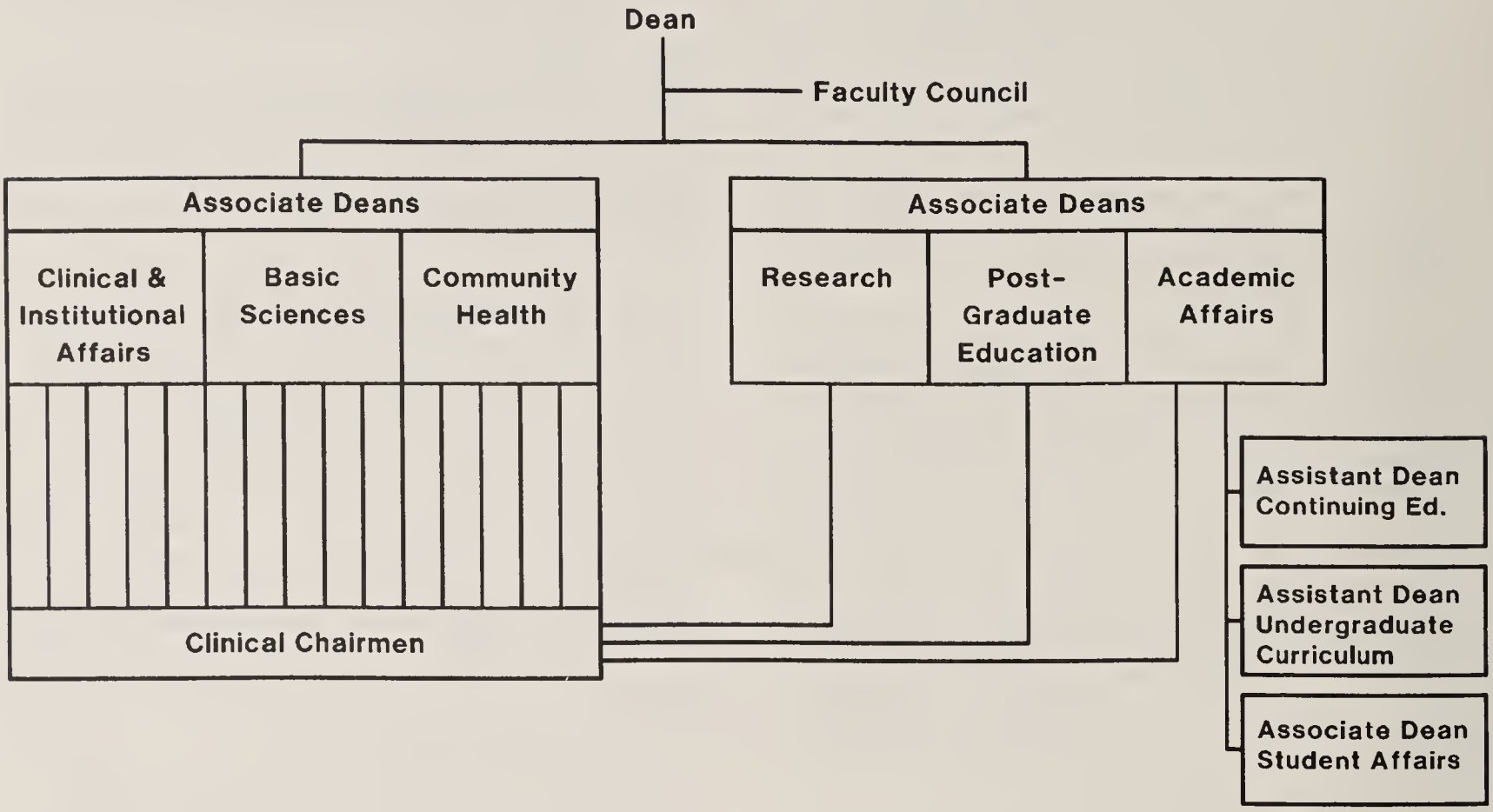


EXHIBIT 5

DEAN'S OFFICE - 1980-84

Dean:	F. H. Lowy (1980 -)
Associate Dean, Academic Affairs:	W. H. Francombe (1976-1984)
Associate Dean, Student Affairs:	E. Llewellyn-Thomas (1974-1984)
Associate Dean, Postgraduate Affairs:	R. H. Sheppard (1977 -)
Associate Dean, Research:	K. J. Dorrington (1981-82) B. J. Underdown (1982-1984)
Associate Dean, Clinical and Institutional Affairs:	W. M. Paul (1980-82) J. T. Marotta (1982-)
Associate Dean, Basic Science:	K. J. Dorrington (1980-81) D. W. Clarke (1981-84)
Associate Dean, Community Health:	E. Vayda (1981-)
Assistant Dean, Continuing Education:	F. B. Fallis (1981-)
Assistant Dean, Undergraduate Curriculum:	E. M. Sellers (1982-84)
Chief Administrative Officer:	J. D. Kraemer (1975-)
Faculty Development Officer:	J. W. Browne (1981-84)

of our best young scientists this year, whether they had firm University funding or not, and put them forward for the MRC Career Scientists Award. This led to three awards — the most to any one university in Canada this year. Also, the recent biotechnology development program at MRC received a number of preliminary applications, of which Toronto's was reported to be the best. We have been encouraged to begin recruitment for this program in developmental genetics with a high probability of MRC funding, provided we bring forward well-qualified candidates.

3. FACULTY ORGANIZATION

a) Dean's Office

Further to advice from external consultants (S. Ruma, MIT-Sloan School of Management, and C. Birkett, Hickling-Johnson), Dean Holmes had begun to implement a major reorganization of the Deanery by the time I took office, and its present configuration is based upon this. It is a matrix in which each department chairman is responsible to one of the three sector deans (Basic Science, Clinical and Community Health) with respect to budget, personnel and other administrative matters, yet relates to each of the programmatic deans as required, i.e. Research, Academic Affairs, etc. The organization of the Dean's Office is depicted in Exhibit 4, opposite; the people who have occupied the various offices are listed in Exhibit 5.

The need for an Associate Dean — Research, was stressed by a number of investigators located in both the Medical Sciences Building and the hospitals. With the hospital research institutes in varying stages of active planning, and the pressing need to protect our research effort at a time of major budget cuts, I established an associate deanship for research in 1981. Drs. Dorrington and Underdown, who have held this post, have established a highly effective Faculty Research Office, a Hospital University Research Coordinating Committee, and a restructured Faculty Research Committee. Dr. Underdown and his staff are working to establish a computerized research data base linking all of the Faculty's operations.

New assistant deanships have been established for continuing education and undergraduate medical curriculum to emphasize the importance of these areas. Dr. Fallis, the first Assistant Dean — Continuing Education, has brought together the many departmental and divisional continuing education offerings, has established standard advertising formats and a distinctive logo, and has placed the C.E. office on a firmer financial footing. To illustrate the scope of activity, during 1982-83, 3016 registrants participated in 45 short C.E. courses. Moreover, in conjunction with the Toronto General Hospital and the Royal College of Physicians and Surgeons of Canada, Dr. Fallis has established an effective and rapidly expanding telemedicine educational and consultation link with professionals in many parts of the province. This likely will develop much further during the new few years.

All of the associate and assistant deans are only part-time administrators in my office; they also continue to teach and conduct research or clinical programs in their own departments. The matrix organization and the growth in the number of people associated with the Dean's Office represent attempts to manage a multimillion dollar, diverse and dispersed Faculty. It is notable that only twenty years ago a part-time dean and three assistants managed the Faculty's affairs. Of course, at that time the post-graduate medical programs were the responsibility of the hospitals and not the Faculty, our continuing education programs barely existed, the number of undergraduate and graduate students and staff was much smaller, and the entire Division of Community Health did not exist in this Faculty.

Although the Deanery may seem complicated and perhaps even top heavy, this present organization was recommended by external consultants precisely because of the complexity of our programs and our size. It was reassuring in this connection that the LCME-CACMS reviewers in 1983 concluded that: "The new organization of the Dean's Office with its matrix reporting system is appropriate to the size and diversity of this Faculty of Medicine. It is staffed by competent individuals."[6]

It would be wrong not to mention in this section the crucial role of the administrative arm of the Dean's Office headed by Mr. J. D. Kraemer, Chief Administrative Officer. This position was created in 1978. Coincident with my becoming Dean, Mr. Kraemer had to introduce a number of new key administrative personnel and reorganize the Faculty's finance office. It is a credit to him and his staff that this Faculty is generally considered to have one of the most effective administrations in the entire University. Furthermore, a measure of its efficiency is the number of existing administrative and service units that are almost totally self-supporting.

b) New Chairmen

The two most important determinants of the quality of life in an academic institution are, of course, the quality of the students and the quality of the teaching staff, and the two are related: good teachers and researchers attract good students. In turn, their quality, as well as many other aspects of the academic climate, is influenced heavily by the quality of the department chairmen. It is one of the Dean's most important tasks to ensure that the most suitable people available are appointed to these important posts.

During my first two years as Dean, much of my energy and time (as well as those of some Associate Deans) was devoted to searches for new department chairmen. During the three years 1980-83, no fewer than 17 new department chairmen were appointed and five others were reappointed for a second term. In addition, new directors were appointed for the Banting and Best Diabetes Centre, the Institutes of Biomedical Engineering and Medical Sciences and the Occupational and Environment Health Unit. The department chairmen who have served during 1980-1984 are listed in the Appendix.

This presented me and the various search committees with the opportunity to appoint vigorous and forward looking new academic leaders who will direct the Faculty's programs throughout this decade. For the most part the searches were national, and often international. In all cases, the most important criterion for the appointment was high potential for advancing the academic performance of the department or unit, given its particular stage of development.

The search committees were diligent and discerning. Therefore, it is instructive to look at their results and our success in implementing their recommendations. In all searches, the preferred candidates were attracted initially. Of the 21 candidates ranked first by search committees (17 chairmen and four directors), we were eventually able to attract 12 (nine chairmen and three directors), that is, 57% of the candidates. Six of the nine first choice candidates we lost were Americans and the other three Canadians. In six cases, we simply could not match the resource demands of the candidates (though in all instances we tried hard), and in three cases non-resource related personal reasons seemed most important. As it happens, I personally am extremely satisfied with the appointments that were made, including those chairmen who initially were not ranked first by the committee but who have, in fact, proved to be remarkably suitable choices.

This notwithstanding, it is clear that in an international search our medical school is attractive enough to cause potential chairmen who are international stars to bite, but not wealthy enough to land them. It should be pointed out that, in several searches, outside candidates (some from the United States and Britian) were on the short lists but were not ranked as high as local candidates who have scholarly reputations that are as great or greater. In all, of the 17 new chairmen, 13 were appointed from within the Faculty as were all four directors.

I wish to point out also that a number of other senior appointments were made of new hospital chiefs and divisional heads in the clinical departments; a greater proportion of these were external appointments. In this regard, I wish to express my thanks to Vice-Provosts Kingstone and Hollenberg and Presidents Ham and Strangway for the assistance they provided in each case in relation to the Canadian immigration authorities.

c) Planning Mechanisms

As I pointed out in the introduction to this Report, by 1981 the Faculty was at the end of the planning cycle begun in 1975, possessed a large number of new chairmen, and was looking forward to major external reviews of its postgraduate, undergraduate and graduate programs in 1983. I asked the Senior Advisory Committee to suggest ways by which we could examine the forces impinging on the Faculty over the next few years, and develop plans and objectives for the future. These steps could then be married to the assessment of our programs. The Senior Advisory Committee established three Task Forces to examine University/Faculty relationships, Faculty/Teaching Hospital relationships, and Faculty Development.

The Faculty Development Task Force, chaired by Dr. Charles Hollenberg, advocated that planning and budgeting are inseparable activities and should be conducted in large part at the level of the Faculty's three divisions. Mechanisms had to be found for encouraging and facilitating iterative planning and budgeting on a regular cycle and in a structured way by each department, integrating the contraction and expansion plans of the various departments, evaluating new initiatives requiring major resource commitments, and matching budgets to the plans and responsibilities of each department. This activity appeared to be best conducted at the divisional level by groupings of department chairmen or other senior Faculty members, with management and planning responsibility delegated to the sector Associate Deans.

In the Basic Science and Community Health divisions, planning was felt to be adversely affected by three main factors:

1. a multiplicity of small departments with limited flexibility because of both size and the commitment of a large proportion of the budgets to tenured staff;
2. a space policy that does not readily allow the reallocation of space according to function; and
3. major teaching committments to University programs outside the Faculty of Medicine.

To make planning more effective in these two divisions required a broadening of the base of planning and budgeting beyond the individual departments, while preserving departmental structures and identity.

Acting on the advice of the Task Force report, in June, 1982 I asked the sector Associate Deans and their Chairmen to form Planning and Budget Groups that would:

- discuss appointments and tenure stream requests before these are submitted to the Dean;
- approve new program submissions from departments and interdepartmental sources before submission to the Dean; and
- consider budgets as allocated to the group of departments as a whole so that they may reflect plans and priorities established by the new planning process.

In the Community Health division, with fewer units and a tradition of joint planning throughout its brief history, it was not difficult for Dr. Vayda and his colleagues to apply this model. Divisional objectives and priorities, approved in my office, are guiding new appointments and will guide the allocation of new funds as they become available.

In the Basic Science division, with a more disparate group of departments that represent disciplines rich in tradition, the task has proved more difficult. The Faculty Development Task Force originally recommended that this division be divided into two Planning and Budget Groups representing, respectively, those disciplines that work largely at the cellular and molecular level and those whose interests are largely systemic (at the level of the whole organism). The Basic Science chairmen were reluctant to follow this approach and have attempted to respond to my memo by functioning as a single group of ten units. This has not resulted in the joint planning and budgeting envisioned by the Task Force and has not provided the Dean's Office with policy advice regarding new initiatives.

There has been a sluggish response to the challenges and opportunities posed by the development of the new hospital research institutes which will contain many new basic science laboratories. In view of this and the clear message from the University's central administration that new appointments and budgetary submissions will be evaluated against approved plans and priorities, in December, 1983 I met with the Basic Science chairmen and asked them to reconsider the establishment of two planning groups with special attention to research development. Simultaneously, the Faculty Research Committee began to identify areas of major research opportunity for the Faculty and Dr. Underdown has solicited "grass-roots" advice on this point.

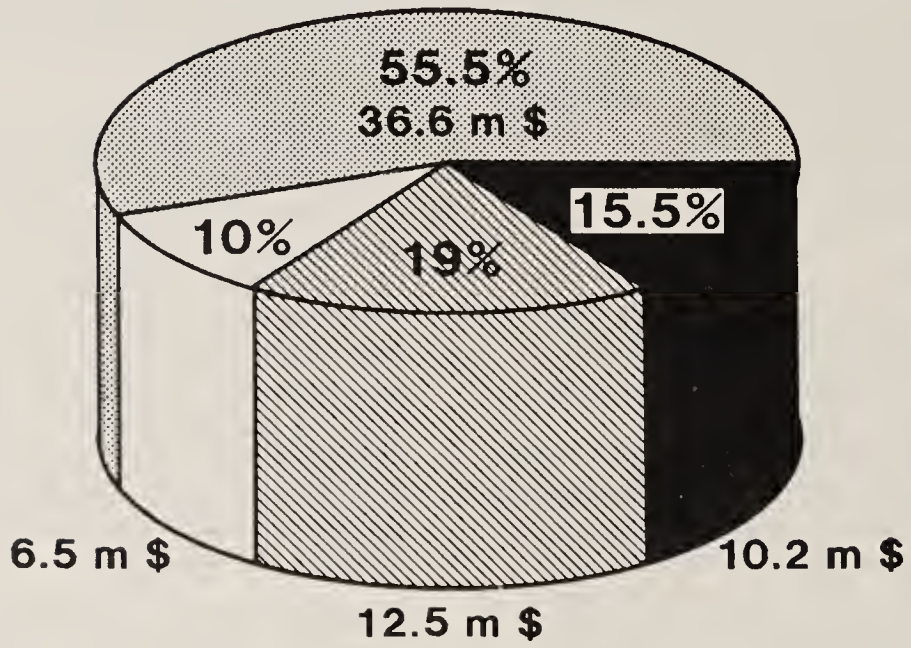
This Faculty has a strong tradition of leadership in basic research, going back to Professor A. B. MacCallum at the turn of the century who was credited by the Royal Society of London with having converted the medical school from an institution, in the 1880's "in much the same condition as an English provincial school" to one that "thirty years later ranked among the top two or three in North America and could teach the world"[7] by the establishment of research, scholarship and graduate studies at the doctoral level.

It is imperative that this tradition of excellence be maintained. Although the LCME-CACMS review of medical undergraduate programs and the OCGS review of graduate programs praised the quality of teaching, there was criticism that some of our basic science research programs are not reaching potential and are not at the cutting edge of science. Dr. Clarke and the Basic Science chairmen are now exploring another way of meeting the planning challenge by identifying clusters of research themes and bringing together those departments with expertise and/or interest in them.

The clinical departments present different planning problems. They are large, geographically dispersed and do not rely only on University funds for their operations. They have very few tenured staff. Although they have had operational flexibility, there is corresponding organizational complexity which makes even intradepartmental planning complicated, while interdepartmental planning can be daunting in the extreme. Coordination of the

EXHIBIT 6

1983-84
Gross Budget
65.8 million $



Base
T & R Recoveries
Clinical Recoveries
Income

multicentred operations of these departments is needed to ensure that their separate development does not produce unnecessary duplication, and that planning conforms to Faculty and teaching hospital objectives.

The Task Force recommended a Clinical Planning and Budget Committee that would be comprised not of clinical chairmen but of senior clinical faculty members who would advise the chairmen and the Dean. The clinical chairmen were reluctant to proceed in this direction and recommended instead the establishment of a small planning committee from their own ranks. This has been done and Dr. Marotta and five chairmen have constituted this group. Their efforts to date have been concentrated primarily on developing a new Clinical Appointments Policy, including a definition of criteria required for entry into the full-time academic stream and the responsibility of the University and the teaching hospitals to those colleagues who achieve this status.

Because of the close interdependence of the academic and clinical activities in these departments, and the heavy impact on them and the teaching hospitals of major decisions made by either party, it is essential that our planning mechanisms in their area provide for appropriate consultation and, at times, joint University-hospital decision making. Accordingly, at least two chairmen of the Clinical Planning Group (the Chairmen of Medicine and Surgery) are also members of the Health Science Complex Management Advisory Committee, which I will discuss later in this report.

d) New Structures

In 1980 the Faculty was organized into 37 academic operational units (27 departments, four units that reported through departments, five interdisciplinary units and the Hannah Chair for the History of Medicine), as well as academic support units and administrative departments. In addition to the traditional academic departments common to most medical schools, this Faculty also has separate departments of Art as Applied to Medicine, the Banting and Best Department of Medical Research, Behavioural Science, Health Administration, Medical Biophysics and Nutritional Sciences, as well as an Occupational and Environmental Health Unit that functions very much as a department. Inevitably, there will be periodic attempts to coalesce departments and to form new ones; both have occurred during the past three years.

Since the merger of the Faculty of Medicine and the School of Hygiene in 1975, there had been two departments of microbiology: medical microbiology, a hospital-based infectious disease oriented clinical department, and microbiology and parasitology, a basic science department oriented to basic biological processes in microorganisms and environmental and non-medical microbiology. After much discussion by the departments, the report of a task force chaired by Dr. K. J. Dorrington, and heated debate at Faculty Council, the University Governing Council accepted our recommendation that the two departments be merged under the leadership of a single chairman, with a review in five years. Dr. L. B. Spence, who had been Acting Chairman of Medical Microbiology, was appointed Chairman of the combined Department of Microbiology.

Unfortunately, it turned out that this department was born at the worst possible time from the points of view of Faculty budget cuts and the loss of our tenure pool, an event which will be considered in greater detail later in this report. To date we have not been able to fulfill commitments made to Dr. Spence and the combined departments with respect to guaranteeing replacements for all of the planned retirements and the needed renovation of space in the FitzGerald Building.

Another field that has received a great deal of administrative and planning attention is immunology. A large number of immunologists, some of international stature, have been involved in the teaching, research and clinical programs of several departments. Graduate teaching was conducted within the Institute of Immunology. There was concern both within the Faculty of Medicine and the School of Graduate Studies that the existing program was not making the best use of Toronto's strong potential in this rapidly moving field. A task force chaired by Dr. I. B. Fritz examined this and recommended that a Department of Immunology be established. It was felt that this structure, the traditional academic unit, is more likely to advance what has become a discipline in its own right and an important scientific area of growth. Although Governing Council approval was granted in 1983, we have delayed the formal establishment of the Department until the first chairman could be installed in July 1984. Dr. R.G. Miller has been recommended for this position.

Four other programs have requested departmental status, but careful study is required before I can give a positive recommendation to Governing Council; alternative options must be considered closely. Status change has been proposed for:

1. Radiation Oncology, currently a division of the Department of Radiology;
2. Occupational and Environmental Health, currently a free standing Community Health unit;
3. Neurology, currently a division of the Department of Medicine; and
4. Emergency Medicine, currently an interdepartmental program.

The Dean's Office and the Senior Advisory Committee have examined the Department of Rehabilitation Medicine because of concern about the four academic programs for which it was responsible. Following an external review of the Department, it was decided to detach Speech Pathology, for which administrative arrangements have not been finalized. Dr. J. T. Marotta has been Acting Chairman for the past several months and has recently submitted a plan for the development of quality programs in the remaining divisions (Physiatry, Occupational Therapy and Physical Therapy) within the context of our budgetary realities.

e) Budget and Personnel

The major point of friction between the Faculty of Medicine and the University's central administration has been the annual budget. Although we believe that this Faculty meets the University's major criteria of priority — excellence and centrality of academic programs — budget cuts during seven of the past eight years have been disproportionate in relation to the other large faculties (Arts & Science, Engineering, Law) and to the University as a whole. Particularly unfortunate is the view held by the administration that the Faculty is "wealthy" and can absorb successive budget cuts with little difficulty. While it is true that we use our size and organizational diversity to maximize our financial opportunities, these years of disproportionate budget cuts have seriously affected the Faculty.

Let us begin by looking at the 1983-84 budget. Including the T&R funds from the Ministry of Health, clinical salary recoveries, gifts, endowments, and income earned by the Faculty's service divisions, the total operating budget for the Faculty for 1983-84 was 65.8 million dollars (see Exhibit 6, opposite). Of this amount, base budget funds provided by the University come to 36.6 million.

TABLE 6

SOURCES OF FACULTY BUDGET 1978-1983 (MILLION $)

	1978	1979	1980	1981	1982	1983
Total Operating Budget:	37.86	41.19	44.95	49.98	58.84	65.78
— From University	22.99	23.79	25.65	28.46	32.50	36.58
— From T & R	7.01	7.28	7.84	8.59	9.53	10.25
— From Clinical Recoveries	4.80	6.45	7.14	8.40	10.96	12.49
— From Divisional Recoveries	3.06	3.67	4.32	4.53	5.85	6.46

TABLE 7

FACULTY OF MEDICINE BUDGET 1978-1983 (INDEXED AT 1978 LEVEL)

	1978	1979	1980	1981	1982	1983
Total Operating Budget:	100	108.8	118.7	132.0	155.4	173.7
— From University	100	103.5	111.6	123.8	141.4	159.1
— From T & R	100	103.8	111.8	122.5	135.9	146.1
— From Clinical Recoveries	100	134.3	148.8	175.0	228.4	260.2
— From Divisional Recoveries	100	120.0	141.0	147.8	191.0	210.9

TABLE 8

COMPARATIVE NET OPERATING BUDGETS 1978-83 UNIVERSITY/SEVERAL FACULTIES (INDEXED AT 1978 LEVEL)

	1978	1979	1980	1981	1982	1983
University	100	104.6	114.7	127.3	145.8	160.8
Medicine	100	103.5	111.6	123.8	141.4	159.1
Arts & Science	100	103.8	114.3	126.0	144.3	159.7
Engineering	100	105.4	117.1	129.7	146.1	166.4
Law	100	105.5	116.4	128.1	149.6	170.4

dollars. That is to say, this year we will earn or recover 29.2 million dollars, or 44% of our operating budget. By far the largest portion of the 29.2 million dollars will be earned by the clinical sector.

The budget for 1983-84 reflects trends that have been growing over many years. If we take 1978-79 as the base year and compare it to the 1983-84 budget, the Faculty's operating budget has increased by 74%. The increase in the University's portion of the budget has only been 59% (see Tables 6 and 7). For comparison, it is of interest that the budget increase for Arts & Science was 60%, for Engineering 66% and for Law 70% (Table 8). Over this period of time the income earned and the clinical earnings recovered by the Faculty have more than doubled. The proportion of our operating budget derived from the University has declined from 61% to 55.5% whereas the proportion derived from the recovery of clinical earnings and hospitals has increased from 12% to 19% (see Exhibit 7).

This is all the more impressive when one considers that the clinical recoveries flowing through the Dean's Office represent only a portion of the financial contribution of the clinical departments (Exhibit 8). Some funds from clinical earnings support departmental research through special foundations or accounts administered locally in the teaching hospitals and, of course, the above figures do not include the free teaching provided by status-only volunteer clinical staff who contribute in this way to the Faculty's operations.

Staffing patterns in the Faculty tell a story similar to that of the budget but show more clearly the contribution of the basic science and community health departments. These departments do not have the same opportunities to earn income as the clinical departments but grants held by them contribute significantly to personnel support within the Faculty.

In 1983-84, the Faculty had a total of 1005 FTE academic staff; 403 supported by the University base budget, 462 FTE academic staff whose funding was earned or recovered, and 140 FTE academic staff supported by grants administered through the University. In other words, the University supported less than half of the academic staff of the Faculty; 60% of the academic staff of the Faculty were supported outside the base budget. Of these, were supported 46% by earned income and recoveries and 14% by grants.

The pattern for non-academic staff is similar but shows an even greater dependence on earned income. This year, 296 FTE support staff were supported entirely by University base budget dollars. 135 FTE non-academic staff were supported by earned or recovered dollars and 384 FTE non academic staff were paid through grants. This means that 64% of the non-academic staff of the Faculty are being supported from non-University funds (17% on earned or recovered money, 47% on grants).

If we look at changes in staffing patterns since 1982-83, it is clear that any staffing gains have been made completely outside of the University budget. In the past two years, the academic staff of the Faculty has been increased by a net of six FTEs. The increase came about in the following ways. We reduced the base budget complement of academic staff by 14.5 FTEs, and 29 FTEs supported by earned or recovered dollars were also eliminated. Salary support from other sources was found for 50 FTE academic staff, thereby generating the net gain of six. Support for non-academic staff was more difficult to find; as a result, non-academic staff have been reduced by 35.5 FTE (mostly by attrition) since the 1982-83 academic year.

By using clinical earnings, hospital contributions, and research funding, we have managed to minimize the damage caused by successive budget cuts imposed by the central University administration and the failure of T&R funding increases to match inflation. In the meantime, the University has continued to benefit from the prestige of our research and medical education programs since they are among the things that the University does well, and from the high level graduate programs provided through the basic science and community health programs which have been supported increasingly by the clinical sector.

However, the budget cuts and the net flow of dollars from clinical departments carry a price. We have now reached the point where we cannot afford to fund many of our own priorities. Morale among the clinical departments may be slipping, and cooperation in the health science complex is being threatened. The Faculty needs some sign of encouragement from the central administration if it is to continue to be entrepreneurial in its operations in order to protect the quality and scope of its academic endeavours.

Specifically, we need to know that our budget will not be reduced disproportionately in the future without proper cause, and that the methods whereby we gain our flexibility will not be restricted by policies and procedures, developed by the central administration, which are more appropriate to other sectors of the University.

4. FACULTY-UNIVERSITY RELATIONS

The Task Force on Faculty-University Relations, chaired by Dr. R.B. Holmes, concluded that there is no friction between the central University and the Faculty with respect to academic standards or academic priorities. However, considerable conflict was identified in administrative and budgetary matters. I have already discussed the budget problems. Difficulties in the administrative area fall under four headings, discussed in the following sections, of reporting relationships, personnel issues, fund raising, and the tenure pool and long-range planning.

a) Reporting Relationships

During Dean Holmes' six year tenure of office, there had been five different reporting relationships to central administration, not all satisfactory from the perspective of the Faculty. My own experience has been more favourable. I have enjoyed good working relationships with Provosts Chant, Strangway and, now, Iacobucci and their Vice-Provosts, Drs. E. Kingstone and C.H. Hollenberg. It has been my understanding that I am responsible to Faculty Council and on to the Academic Affairs Committee of Governing Council for the academic programs of the Faculty, and to the President (and his delegates) for the administration of the resources available to conduct these. The Vice Provosts have had a difficult task, being both staff and line officers. Also, they are at one time the Provost's advisors with respect to the Health Sciences and therefore can be in an adversarial position to the Faculty, and at another time are our advocates in Simcoe Hall Circle, that is, spokesmen for the Faculty.

In addition, Dr. Hollenberg has the role of Special Advisor to the President with respect to the teaching hospitals and external institutions. Thus far, I have not experienced friction resulting from territorial overlap involving the Vice-Provost, the Associate Dean-Institutional Affairs and myself. We appear to be working well together in a complementary fashion, no doubt due to open and frequent communication amongst us.

b) Personnel Issues

University administrative and promotion policies, while quite suitable for most members of our basic science and community health divisions, are at times poorly suited to the needs of our clinical departments. We depend very heavily on the goodwill of our volunteer clinical teachers, who have minor part-time or

EXHIBIT 7

Gross Budget

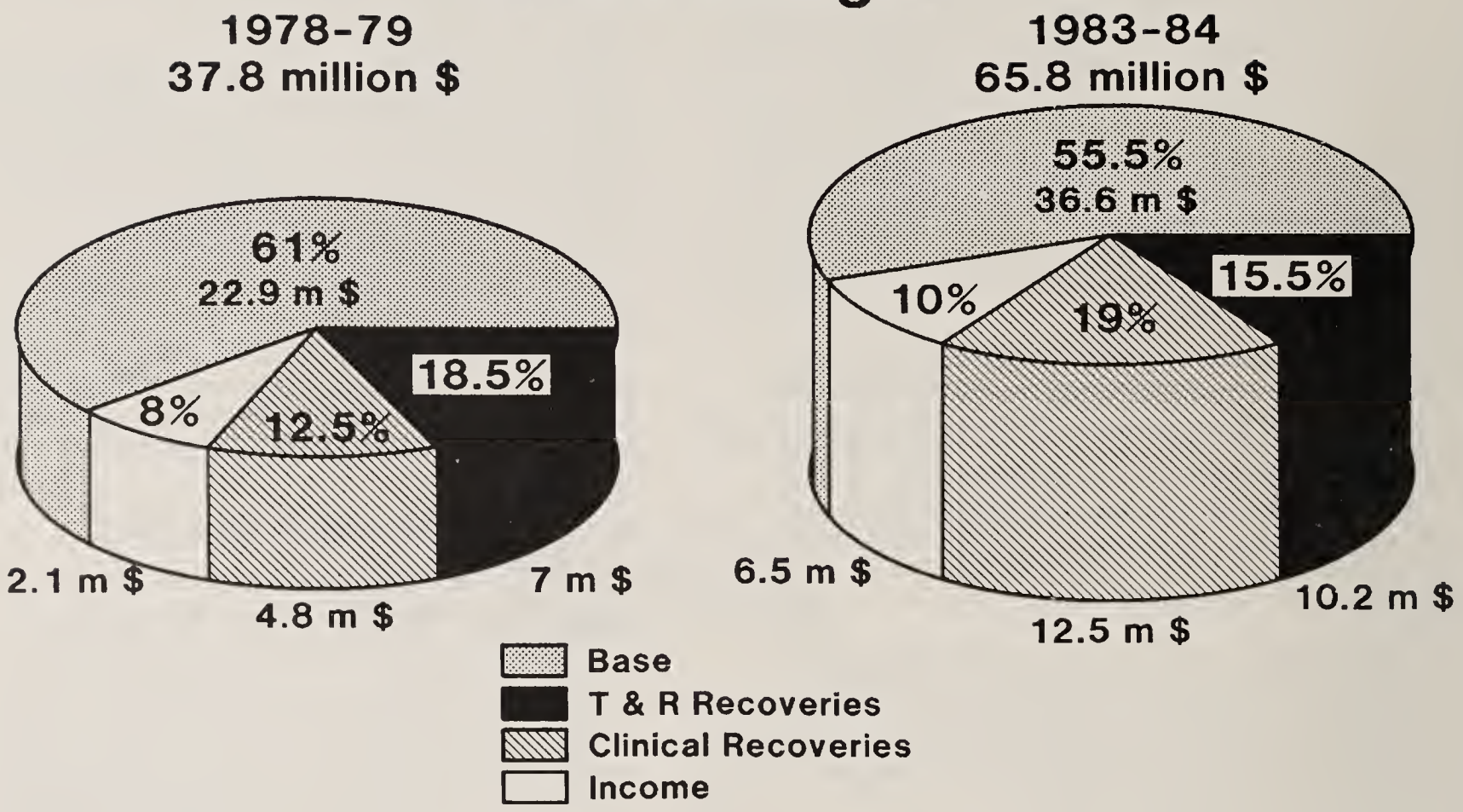
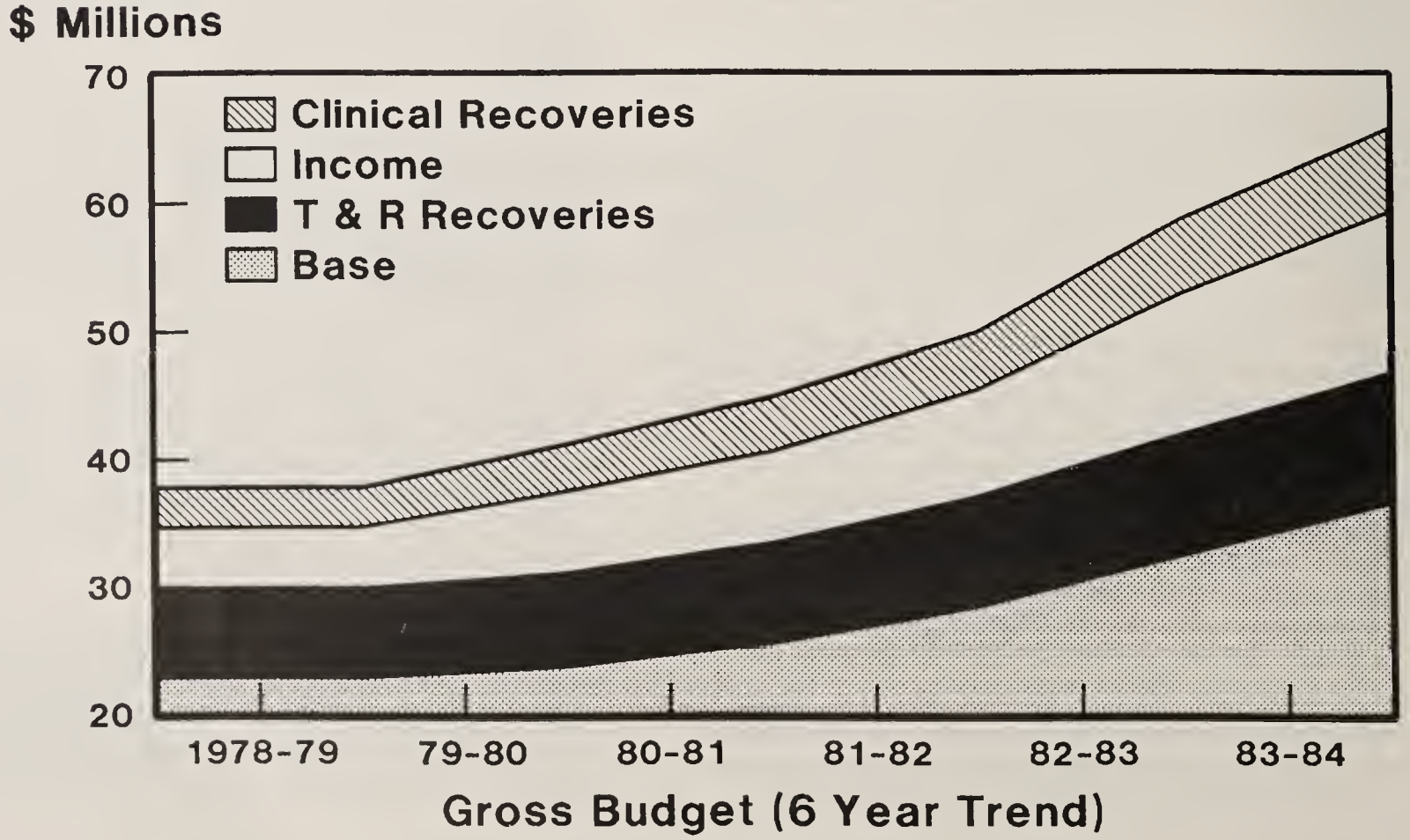


EXHIBIT 8

FISCAL RECOVERIES



status-only University appointments. There is insufficient recognition for these volunteer teachers. Promotion is difficult for them to achieve and they are not eligible for most University benefits. In this regard they are often in double jeopardy: the Faculty does not have the money to pay them what their teaching services are worth, and because they are not paid, they are ineligible for University benefits.

I know that the senior officers of the University are aware of this problem and I am confident that when we submit a Clinical Appointments Policy, which I shall mention shortly, we may expect a sympathetic response.

A related problem is the central administration's eagerness to establish a complement plan in the clinical departments similar to that which is being developed elsewhere in the Faculty and the University. While the proposed new category of Full-Time Continuing Clinical Appointment and the clarification of the Full-Time Annual Appointments will assist personnel planning, we will continue to require discretionary flexibility in making clinical appointments.

According to the affiliation agreements between the Governing Council and the Boards of the fully affiliated teaching hospitals, all physicians appointed to these hospitals also must be appointed to the University. This interrelationship has led to a number of difficulties in personnel policy, yet it is the only means by which the Faculty can assure control over the quality of teaching and clinical role-modelling in the post-graduate medical program. Therefore, although the Faculty understands and generally supports the principle of complement planning, we do need to increase the staff complement from time to time in response to the service demands upon the hospitals. This issue will grow in importance, since some life support and tertiary care programs are developing in our hospitals that are beyond the teaching requirements of the Faculty, yet very much in the public interest. Of course, some of these appointments are often part-time or status-only.

A related problem is that the appointment and promotion policies of the University do not now fully recognize staffing requirements which allow for the effective execution of academic and patient care imperatives. Some clinical departments or divisions are best viewed as single, functional academic units in which certain physicians, having been primarily assigned to patient care duties, agree to share their higher income so that their colleagues can devote more time to research and scholarship. Local rewards are possible for these physicians, but the current University rank structure is not designed to recognize their full contribution to the department. Here it is as if the goal-keeper on a team fails to get recognition because he scores no goals.

c) Fund Raising

A lack of autonomy in fund raising has been another point of friction between the Faculty and the central administration. We fully understand the need to avoid multiple University approaches to a single funding source. However, there are many funding sources which the Faculty of Medicine might approach that are unlikely to be solicited by other divisions of the University. Current University practices make it much more attractive for our clinical chairmen and division heads to persuade their hospital boards to undertake fund raising efforts to facilitate their academic development than to run the administrative gauntlet required to approach potential donors in the name of the University.

d) Tenure Pool and Long Range Planning

Perhaps the most serious unresolved problem with Central Administration relates to the loss of the Faculty's tenure pool in 1982. When I became Dean, the Faculty had a tenure pool of 250, which was scheduled to be reduced to 243. This arrangement, which had been worked out with Professor Donald Chant when he was Provost, provided a structure within which the Faculty could plan future developments. On this basis, Dean Holmes instituted three year budgeting for departments; this encouraged them to undertake medium range planning. In 1982, Provost Strangway decided to suspend the tenure pool and to require the Faculty of Medicine, like all other faculties, to request and justify to him all new appointments or position replacements. During the past year, the centre has recovered each position vacated by retirement, death or resignation and our requests for replacements have been approved or rejected case by case, according to criteria that have not been made public. We have been told that replacements will be approved only in the context of an approved long range academic plan.

As will be readily appreciated, this is a chicken and egg situation: the parameters within which a serious long range plan can be constructed need to be stated, otherwise plans become unrealistically grand; when they cannot be accepted it leads to disillusionment and passivity on the part of the planners — deans, chairmen, departmental committees, etc. The tenure pool provided the necessary parameters. Clearly, the central administration cannot know for certain what the budget and available positions for Medicine will be in five years. However, on the basis of forecasts and the University's overall forward planning, the President and Provost ought to be prepared to guarantee to faculties a minimum number of replacements for planned retirements to provide a structure for planning. Without this, there is little incentive to do the difficult, time-consuming job of planning, and the necessary link between planning and budget preparation is broken.

Another adverse consequence of the present position-recovery policy is Faculty-hospital friction with respect to the replacement of senior clinical-academic administrators. Clearly, chiefs of service and other senior staff *must* be replaced in institutions that have patient care responsibilities — the University is only one half of the partnership here. Dr. Hollenberg and I have discussed this problem, which he of course understands fully, and I am confident that we will find a solution that the central administration can accept.

On the broader issue, I believe strongly that the Faculty must know its planning parameters, must prepare plans for approval, and then must be guaranteed at least the minimum resources called for and the operational flexibility needed to implement the plans.

5. FACULTY-HOSPITAL RELATIONS: THE UNIVERSITY OF TORONTO HEALTH SCIENCE COMPLEX

A major priority of the Faculty over the past several years has been to strengthen and solidify the network of teaching hospitals that constitute our clinical campus — at any given time nowadays half of our 1000 medical students and all 1700 postgraduate students work and learn in the affiliated teaching hospitals.

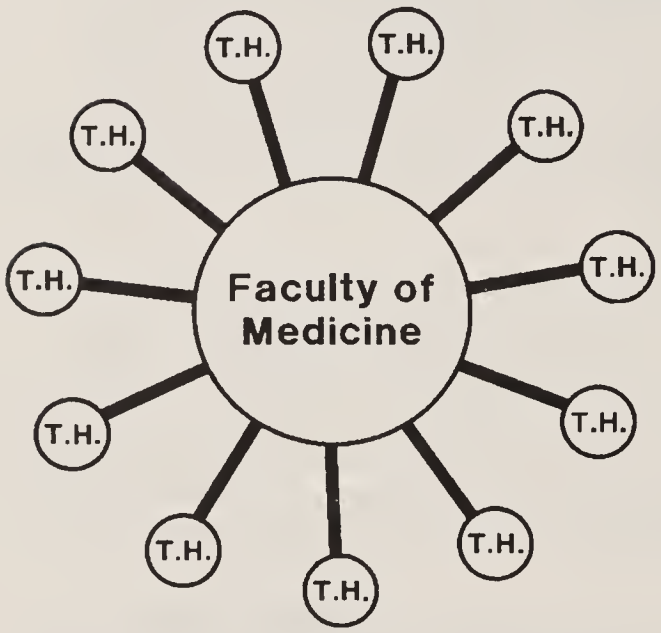
The need for a University-hospital consortium has been recognized for a great many years, but it was not until the decade of the 1960's that it was given formal organizational expression. In 1964, the University Teaching Hospital Association (UTHA) was established to facilitate solutions to shared problems and to advance the hospitals' development.

Although UTHA had strong University participation, it was primarily an association of hospitals. When the Hospital Council of Metropolitan Toronto matured and developed increased capacity

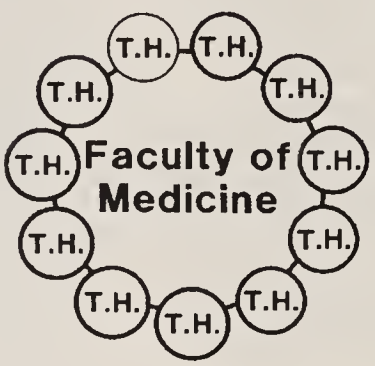
EXHIBIT 9

Hospital-University Relationships

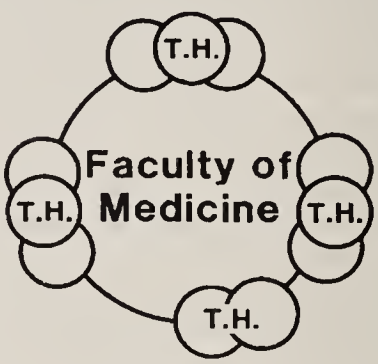
Official University-Hospital Relationship



University-Hospital Overlap



University-Hospital, Hospital Hospital Overlap



to advocate hospitals' positions to government and the public, it was thought that UTHA's objectives could be best met within the larger, more representative body. Specifically, it was hoped that a single hospital position would have a more favourable impact upon the Ministry of Health, and that links between the Toronto teaching hospitals and community hospitals would be stronger if there was not a separate teaching hospital association. This view was not held universally, but after considerable discussion in 1979 and 1980 UTHA was disbanded.

Almost immediately, the University and the fully affiliated teaching hospitals, recognizing the need to maintain organizational links, established the President's Council as an informal organization of Board Chairmen and University officials, to be convened as required to consider matters of joint interest to the University and its principal teaching hospitals.

By December 1982, it seemed clear that more formal organizational links were needed. The only official relationship between the University and each of the hospitals was the bilateral annually renewed affiliation agreement. There was no official link among the teaching hospitals themselves outside of HCMT, a forum not always well suited to the solution of problems that do not primarily concern the community hospitals.

The official relationships as they existed in 1980, and the actual relationships as they evolved, are depicted schematically in Exhibit 9, opposite. In the actual situation, there is an enormous and growing amount of interdependence between the Faculty of Medicine and the teaching hospitals through:

- joint appointments of medical staff and non-medical scientists;
- substantial reciprocal impact of Faculty and hospital forward planning and recruiting policies;
- allocation of students, especially interns and residents; and
- interlinked allocation of staff time and duties, office and laboratory space, etc.

Increasingly, this has resulted in not only a substantial Faculty-hospital overlap but also a growing hospital-hospital overlap.

This state of affairs at the operational level did not have an organizational counterpart. Despite good operational links, particularly between clinical chairmen and their various hospital chiefs and through the operations of the Postgraduate Medical Education and Undergraduate Medical Curriculum Committees, the relationships between the hospital Chief Executive Officers and the Dean's Office were sporadic, and limited to ad hoc problem solving. As Exhibit 10 indicates, communication was mostly up and down the hierarchy of the institutions with insufficient cross-linkages. Board participation was at arm's length, with its only formal vehicle being the annual University-Hospital Liaison Committee meetings that reaffirmed the formal liaison agreements.

This situation was studied by a Task Force on Faculty-Hospital Relations, chaired by Dr. J. T. Marotta. On December 15, 1982, I recommended to the President's Council that a U. of T. Health Sciences Complex Management Advisory Committee be established. This was approved and the committee has met monthly under the chairmanship of Dr. Marotta, as Associate Dean-Clinical and Institutional Affairs. Membership includes the CEO's (Executive Directors or Presidents) of the 11 fully affiliated teaching hospitals, four clinical chairmen, the Dean and the Vice-Provost, Health Sciences, another Health Science Dean and the Chairman of HCMT. This committee has effectively filled the operational/organizational gap depicted previously and already has facilitated Faculty-hospital and hospital-hospital communication, as well as coming to grips with some difficult problems.

As indicated in a previous section of this Report, another linking committee was established at the same time — the Hospital University Research Coordinating Committee (HURCC). Under the chairmanship of Dr. B. J. Underdown, Associate Dean — Research, this Committee brings together the Research Directors or Chairmen of Research Committees of the 11 hospitals to deal with organizational matters in the research field. Also more recently, in November 1983, Faculty Council approved hospital representation on the restructured Faculty Research Committee itself; this committee advises me on research policy and reports to Council.

To complete the final linkage between the University and the teaching hospitals at the Board level, the President's Council has just been restructured under the initiative of Vice-Provost Hollenberg. A Hospital-University Board (HUB) has emerged with the following membership:

- the Board Chairmen of the 11 hospitals, advised by their CEOs or other staff as required;
- the Chairman or Vice-Chairman of Governing Council and three other members, one of whom will be an academic from a faculty other than Medicine;
- the Provost;
- the Vice-President, Business Affairs or Vice-President, Planning and Research, as required;
- the Dean of Medicine; and
- the Vice-Provost, Health Sciences who will chair the Board as the President's representative.

It is expected that this Board, involving the governing and administrative levels of the institutions that constitute the Health Science Complex, will consider policy issues at the interfaces between them and make recommendations to the respective governing bodies (see Exhibit 11).

A further move to strengthen the links has been the invitation by each of the 11 hospitals for a University academic administrator to join their Boards of Trustees. The Vice-Provost, Health Sciences, the Associate Dean — Clinical and Institutional Affairs and I share the honour of sitting on these hospital boards.

In addition to these important structural (or constitutional) developments, a significant joint quality control mechanism was introduced in 1982 with the agreement to conduct five year reviews of Hospital Chiefs. Although University department chairmen are reviewed every five years, and are limited to two terms of office after which an external review of the department is carried out, no such mechanisms existed at most of the teaching hospitals. Under the leadership of Dr. Marotta, reviews of the hospital departments and their chiefs now have been undertaken by means of a process that involves the Board, the administration and the Medical Advisory Committee of each of the hospitals, the Associate Dean and University department chairmen. Most of the reviews conducted thus far have confirmed the high quality of clinical and academic work in progress in our teaching hospitals, but some have resulted in important recommendations to the Faculty and the hospital, including in a few instances the replacement of the chief. The favourable effects of these reviews on quality control and joint Faculty-hospital monitoring of this will be far reaching.

It will be evident from the above that the strengthening of the teaching hospital network has been given very high priority.

EXHIBIT 10

Hospital-University Communication, 1980

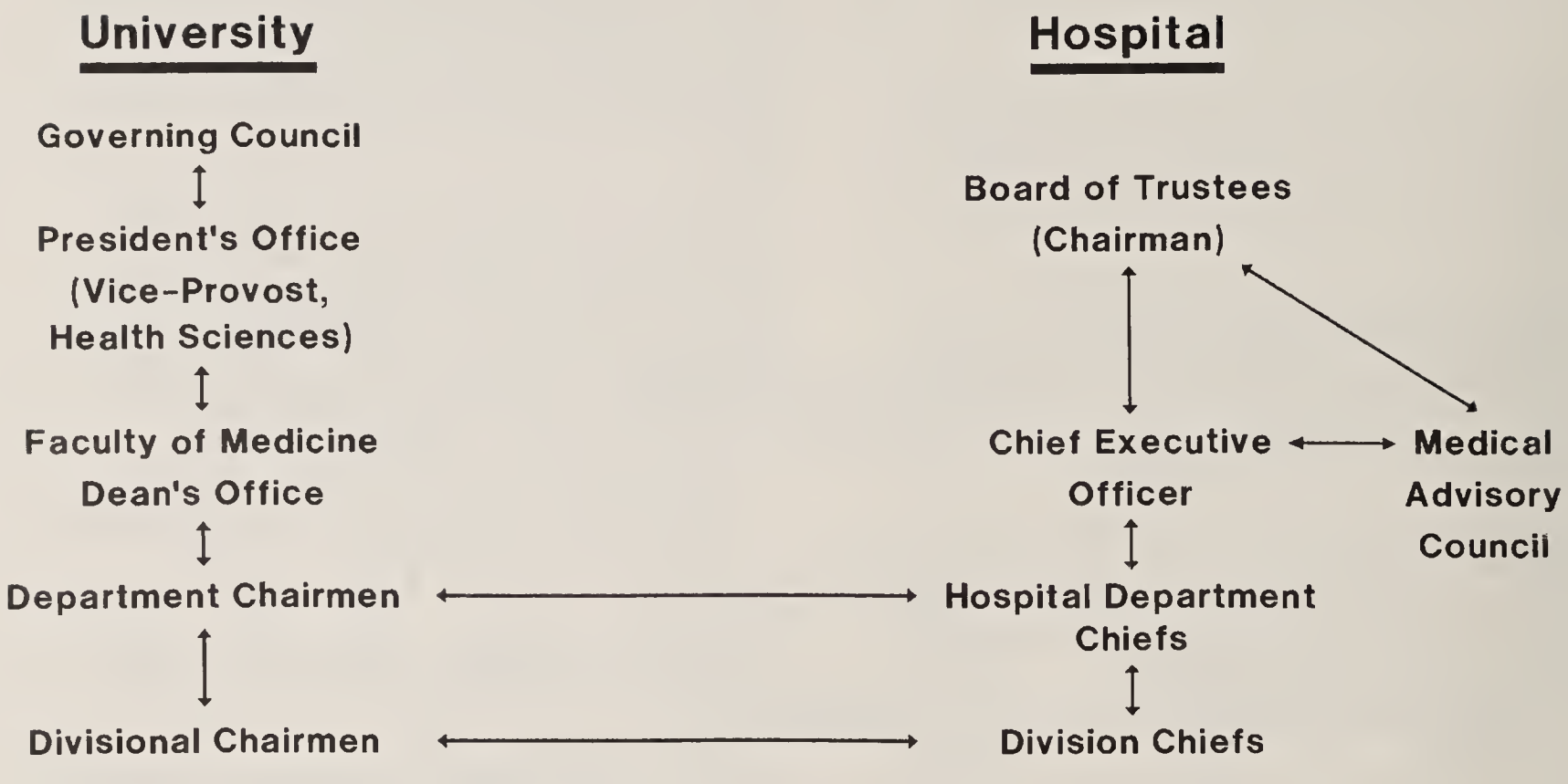
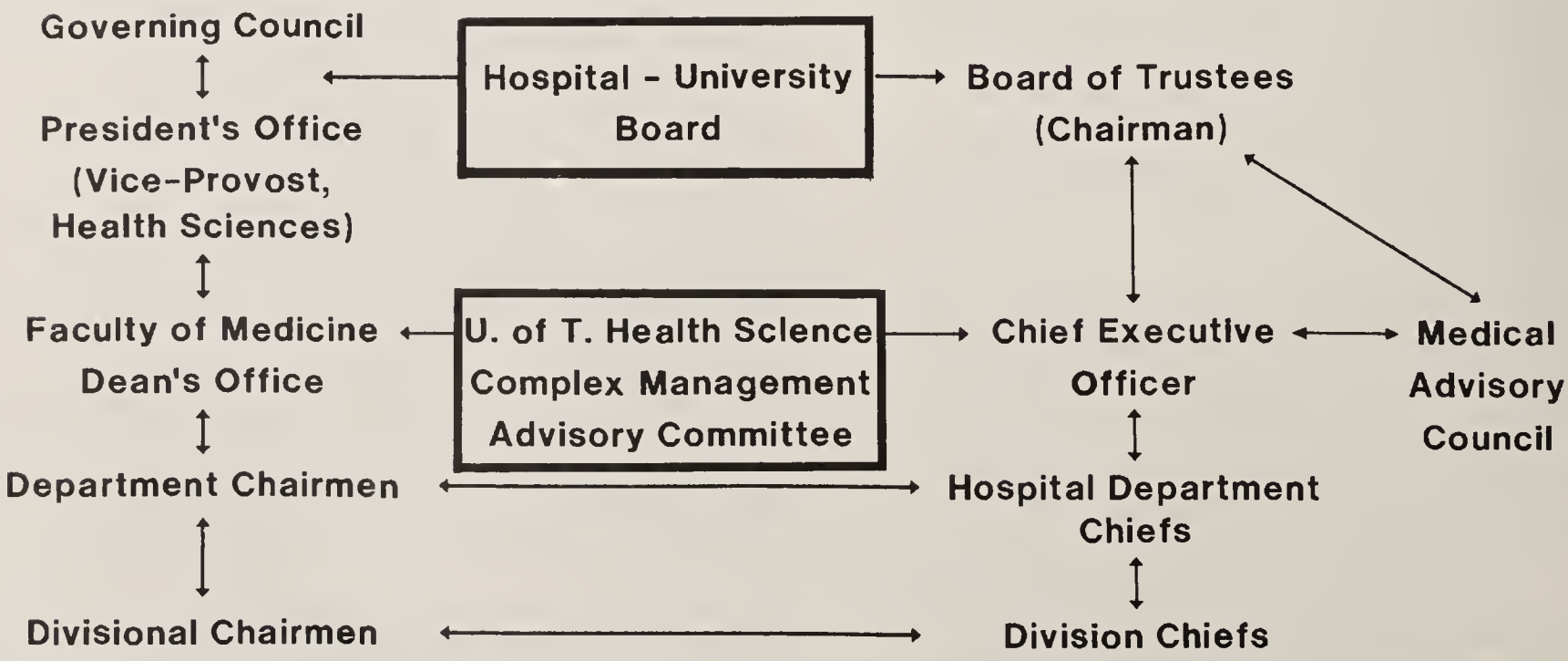


EXHIBIT 11

Hospital-University Communication, 1984



III. STATE OF THE FACULTY — 1984

I have mentioned already that, in the Spring of 1982, the Senior Advisory Committee debated a series of task force reports that were part of an overall planning process begun several months earlier. This aimed to define the current state of the Faculty, to examine the forces impinging on the Faculty and to develop objectives, plans and planning tools. Because of the accreditation site visits scheduled for 1983, the Senior Advisory Committee proposed that the reports of the site visitors, coupled with a self-study, form the basis for comments about the current state of the Faculty.

Three major external assessments were made of the Faculty of Medicine programs:

- the LCME/CACMS accreditation team reviewed the Undergraduate Medical Program;
- the Royal College of Physicians and Surgeons site visit team reviewed all post-graduate residency programs; and
- the Ontario Council of Graduate Studies reviewed all of the Faculty's M.Sc. and Ph.D. programs when its Appraisals Committee examined all life science graduate departments in the Province's universities.

In addition, during the year preceding the LCME/CACMS site visit, Dr. D.R. Wilson chaired a special committee which undertook a self-study of the Faculty.

The reports of these accrediting teams and the self-study, coupled with the many external reviews of individual departments which took place in 1979-80, provide a unique composite "snapshot" of the Faculty. The purpose of this section of my report is to summarize the results of this intensive, external and internal scrutiny to assess the state of the Faculty in 1984, and to consider briefly the strategic challenge that confronts it. In the next section, based upon these factors, I will suggest plans and priorities for the next five years that I intend to present to Faculty Council in detail in due course.

1. ACCREDITATION SITE VISITS

Site visit teams from both the LCME/CACMS and the Royal College of Physicians and Surgeons visited the Faculty in early March, 1983. The final reports from these site visits were received in the late summer. The undergraduate and post-graduate medical programs together are the largest teaching commitment of the Faculty. Therefore, assessments of their quality are significant comments on the quality of the Faculty as a whole.

The medical undergraduate program received a full accreditation for the maximum period of time of seven years. The final report from the LCME/CACMS accrediting commission was highly complimentary to both staff and students. I believe we can take genuine pride in the outcome of this accreditation visit, in our achievements in correcting the deficiencies identified in the previous accreditation report (March, 1977), and in developing new areas of excellence in the medical undergraduate program. The areas of concern identified by the site visit team are very few, and steps have begun already to remedy the deficiencies noted. Principal among these is the revision of the medical undergraduate curriculum which now is occurring, and an in-depth examination of medical student stress which is also in progress.

The report of the Royal College of Physicians and Surgeons survey team was equally favourable. Only four of forty-four programs were given provisional approval. One of these decisions has been appealed successfully because the Royal College Accreditation Committee's decision was counter to the advice of the reviewer himself and the site visit team; action is under way to remedy the weaknesses of the others with the aim of obtaining full approval in 1984. I believe that the acknowledged strength of the Toronto post-graduate program places this Faculty in the ranks of world leaders in medical specialty education. It attests to the dedication of our clinical and post-graduate students, and to the quality and co-operative spirit of our teaching hospitals.

The Ontario Council of Graduate Studies carried out an appraisal of the Life Sciences in all universities in the Province, a considerable task involving visits by teams of reviewers to each department offering a Ph.D. program. The results of these appraisals have just begun to come in on a department-by-department basis. As a result, I cannot yet make an overall comment, but it appears so far that the results of the OCGS appraisals are not markedly different from those of the self-study team which completed its work in February, 1983.

The self-study team, chaired by Dr. D.R. Wilson, visited each department in order to help chairmen reflect upon the strength and weaknesses of their departments. The team deliberately chose to concentrate on deficiencies and its comments frequently were pointed. Nevertheless, the overall impression one gains from reading the report is that the majority of the Faculty's departments and programs are strong and well managed. More important, however, is a sense of how accurate was our impression of ourselves in comparison with the external accreditation reviews. Copies of the self-study report have been distributed to all chairmen.

In summary, the extensive reviews of 1983 indicate clearly that the Faculty of Medicine is strong overall and has many points of excellence. I believe it is important that we recognize the number of things we do well and how important they are at the local, provincial and national levels.

2. THE STRATEGIC CHALLENGE

Although the Faculty is strong and has many high quality programs, there is no doubt that we can and should do better:

- some programs are not among the very best in Canada but could be;
- some programs could compete better at the most advanced international level;
- we are weak or poorly organized in some of the most exciting growth areas in biological science;
- we do not facilitate interdisciplinary and interdepartmental initiatives sufficiently;
- we have not exploited the advantages of our size and high patient volume, e.g. the opportunity for systematic clinical outcome studies and other clinical epidemiological research; and
- we do not have good research space for new investigators, with some departments especially disadvantaged.

Some of these deficiencies can be corrected with better planning and organization. All will require resolute and firm commitment. But most also will require more money at a time when the University is projecting shrinkage over the next decade.

In the face of this dilemma, we have two broad policy options: to become more modest in our ambitions or to be aggressive and flexible so that we can achieve our objectives despite the prospect of, at best, no growth in our University-derived funds. I most strongly recommend the latter, though we may well have to retrench in certain areas and be highly selective with respect to new initiatives. But there should be no doubt as to where I stand: *This Faculty must move forward!* and during the remainder of my term as Dean I will continue to push for this. In Canada today this is the only medical school with the human and physical resources to join the elite group of leader institutions on the world scene. We are not quite there yet, but we can do it!

What are the strategic prerequisites to achieving this goal?

1. We must persuade the central University administration not to penalize us for entrepreneurial initiative and self-sacrifice by taking advantage of the flexibility that these have given us; i.e. by not cutting our budget disproportionately but instead encouraging us to use non-University funds to seek excellence.

2. We must continue to support the growth of academic activities in the hospital sector of thé Health Science Complex, our "second campus"; this sector has opportunities for mobilizing funds and creating research space well beyond what is possible for the university itself. This will require even closer integration of the Health Science Complex.

3. We must expand our own fundraising activities in collaboration with the rest of the University, and carefully explore possible links with industry.

4. We must reduce our allocation of resources to programs that are not successful and have low prospects for success (unless they are central to our objectives, in which case they must have priority for development).

The strategic challenge for the Faculty is exciting. It is nothing less than achieving parity with the best in the world, something that a few (but very few) Canadian institutions and individuals have achieved.

EXHIBIT 12

FACULTY MISSION STATEMENT, 1983

The mission of the Faculty of Medicine is to generate and disseminate new knowledge about human biology, health and illness and to educate practitioners and scientists in the fields of medicine and health care. Specifically, the Faculty will:

(a) conduct research in basic and applied disciplines related to human biology, health and illness;
(b) educate persons to be physicians, scholars in basic and applied science, and other health care professionals, with the aim of producing leaders in these fields; and
(c) assist affiliated institutions in the University of Toronto Health Science Complex to provide exemplary patient care.

The Faculty will carry out this mission within the overall objectives of the University of Toronto, paying particular regard to the criterion of excellence and with due attention to the needs of society.

The Faculty's mission of research and education falls into three areas:

(a) the basic and applied sciences relating to human biology, health and illness;
(b) the clinical sciences relating to patient care; and
(c) the analysis and formulation of health policy relating to society as a whole.

IV. PLANS AND PRIORITIES: 1984-87

Many department chairmen have already submitted three year plans. In the next few months, and prior to the completion of the next budget cycle, I would like each Associate Dean and each Chairman to focus upon three strategic questions:

1. What are we doing now that is both excellent and necessary?
2. How can we continue to do it in our unfavourable fiscal climate?
3. What can we consolidate or discard amongst our programs?

At the Faculty level, I intend to begin formulating an answer to these questions by developing a consolidated statement of objectives. The last Faculty mission statement was approved in November, 1976. Last year, a draft of a new mission statement (Exhibit 12) was prepared and discussed in the Dean's Office and within the committees of chairmen. I now would like to have a fuller discussion of this draft within the Faculty so that a mission statement can be presented to Faculty Council during the next few months. The mission statement emphasizes the priority of excellence, leadership and science, while preserving our high educational standards. I believe we can best serve society, in Ontario and Canada, by doing very well those things that we are better equipped to do than are other medical schools.

In addition, in conjunction with the Associate Deans and the Vice Provost, I have developed a list of issues which I would like discussed within departments and divisions within the next few months, so that a consolidated faculty plan can be submitted to the central administration along with the 1984-85 budget.

1. BASIC SCIENCE DIVISION

I am in the midst of a series of meetings with Basic Science chairmen to review the goals of his or her department. These interviews are based on the accreditation documents, the self-study, and the OCGS reports when the latter are available. However, certain broad problems are shared by all Basic Science departments, and were identified by the Senior Advisory Committee Task Force on Faculty Development. They have already been mentioned in this report.

One of the major organizational problems facing the division as a whole is the lack of congruence between research activity and opportunities and the traditional departmental boundaries. Although I do not favour a reorganization of the division — many functions are best carried out within a stable departmental structure (teaching, promotion, career development) — I believe we must move more forcibly towards a "matrix" system within which crossdepartmental groupings are encouraged for research and for the exploitation of major new technologies.

Among the first priorities of such groupings, it is easy to identify the neurosciences and the development of a biotechnology-genetics group. I hope that other groupings which might be developed in the future will emerge from the work of the Basic Science chairmen and other Faculty committees.

I would ask Basic Science chairmen to co-operate fully in consolidating the Faculty's efforts in Immunology and Microbiology. These departments will require the support of the division as a whole if they are to establish themselves firmly at a time when there is considerable competition for space, posts and money.

As for space, I have identified the renovation of the FitzGerald Building as the first capital priority for the Faculty of Medicine. This must, however, fit in with the overall academic planning for the Faculty. Thus, I urge Basic Science chairmen to move as quickly as possible to identify departmental and divisional priorities.

Closely tied to the question of space is the growing relationship of the Basic Science departments to the teaching hospitals. The growth of research institutes within many of the affiliated hospitals offers enormous opportunity for binding the Health Sciences Complex together more closely, as well as for enhancing the quality and the scope of scientific research carried out within it. We are close to developing an overall policy governing the relationship of the Basic Science departments with the research activities in the teaching hospitals. I would ask each chairman to begin to identify both the areas of research and the specific hospitals with which productive and useful research relationships appear especially promising.

Notwithstanding the need to develop research initiatives, I wish to state clearly that I recognize the importance of teaching in the academic disciplines represented by the departments and the load that teaching activity places on their staff. To this end, the Dean's Office is collecting data about teaching — particularly service teaching to other faculties — so that we can begin to rationalize the external demands placed upon it. Data gathered for the LCME/CACMS survey indicated that the average time reported by basic science faculty members as spent in research was 52% and the average time spent in teaching was 35%.

2. COMMUNITY HEALTH DIVISION

Both the self-study and the LCME/CACMS reports complimented the division on its programs and on its progress in integrating itself within the Faculty. Nevertheless, the Associate Deans and I believe further effort is required in this direction. Therefore, I would suggest that increased interaction with clinical departments is the first priority for the division. Such interaction is particularly important in view of the comment made by the self-study team that lack of a co-ordinated clinical epidemiological program is a major deficit of the Faculty. We intend to address that shortly. The division recently has received support from the Connaught Fund to increase its capacity to offer consultative advice and service for clinical investigations; I urge clinical chairmen to take advantage of this development.

Planned revisions to the undergraduate medical curriculum also will permit the division to increase its interaction with clinical departments and, more importantly, with future clinicians. The resource implications of increased divisional involvement in the medical undergraduate curriculum are considerable, but I believe this involvement is critical if the original purpose of the merger of the School of Hygiene and the Faculty is to be achieved. I would therefore ask Community Health chairmen to examine carefully the current array of courses offered by the division to see if economies can be achieved.

The Senior Advisory Committee suggested that the Faculty should play a stronger role in the development of health policy, a role that will become important as new forces impinge upon the health care and educational systems. Therefore, I have asked the Community Health division to take the lead in developing a health policy analysis group. Planning for this initiative, involving members from the other divisions in the Faculty and colleagues at McMaster University, is well under way and has the full support of the Dean's Office.

3. CLINICAL DEPARTMENTS

As with Basic Science and Community Health chairmen, I am meeting with each clinical chairman to discuss future plans for each department. There are, however, broad issues which affect all the clinical departments. These issues arise largely from the organizational complexity of most clinical departments, especially their relationships to the teaching hospitals.

There is no doubt that the clinical departments have enabled the Faculty to continue to meet the severe budget cuts imposed by the University in the last several years. The data presented earlier clearly illustrate this fact.

I have already drawn to the attention of the central administration the two points which follow. First, goodwill among part-time clinical staff is being eroded rapidly . Second, while the University central administration is concerned about the increasing service load borne by the Faculty of Medicine and the increase in its clinical staff complement, it is in part the University's budget policy which forces the Faculty to become increasingly dependent on service activities until such time as these activities can be restructured in a planned way.

These two points lead to the first two priorities which I feel the Faculty should set for the clinical departments. First, the Dean's Office will continue to press vigorously for better fringe benefits for part-time and voluntary staff and for a greater recognition of the role they play in the clinical programs.

Secondly, I would ask the clinical chairmen, as their major priority, to finalize decisions about the role of their department in each of the teaching hospitals and whether there is a need to concentrate resources to maintain the quality of service and teaching programs.

There are two key elements involved in this process:

1. Some of the difficulty in long term planning will be alleviated once the Faculty has formulated a new Clinical Appointments policy. We are working on this with urgency.
2. Appointment policies must facilitate academic commitment and productivity. In other words, clinical departments must be, and must be seen to be, full contributors to the academic life of the University. The self-study and the Royal College survey have identified some departments which are not well developed academically and I will be working with the chairmen concerned to change this.

Some clinical departments have not been particularly well served by the Faculty. Therefore, the ongoing discussion of programs in Rehabilitation Medicine, Speech Pathology and Art as Applied to Medicine will continue to have a high priority in the Dean's Office. I hope that decisions about the nature and organization of these programs will be made before the beginning of the next academic year.

4. PRIORITIES FOR THE FUTURE

The following are specific priority items that my colleagues and I will be addressing; it is not a complete list.

1. Updating Faculty objectives in accord with the mission statement presented to Faculty Council on April 23, 1984 (Exhibit 12).
2. Broadening input into planning and resource allocation beyond the Dean's Office to the three divisions, as already outlined.
3. Developing policies and procedures that will coordinate Hospital Research Institutes with other Faculty activities and departmental policies.
4. Formulating a long range strategic space plan for Faculty development and a more flexible space allocation policy for immediate application.
5. Consolidating and concentrating hospital-based University resources within the teaching hospitals, where appropriate.
6. Implementing renewal of the undergraduate medical curriculum after approval of Faculty Council.
7. Nurturing the fledgling M.D./Ph.D. program.
8. Formulating a Clinical Appointments Policy which will:
   (a) establish a new Full Time category of Continuing Clinical Appointment, and
   (b) clarify conditions for Annual Clinical Appointments.
9. Strengthening the Faculty's teaching and research activities in Geriatrics and Gerontology.
10. Establishing a Chair in Neurosciences and strengthening teaching and research activities in this field.
11. Strengthening and coordinating teaching and research activities in Oncology.
12. Strengthening and coordinating research activities in Clinical Epidemiology.
13. Establishing a Health Policy Research Unit.
14. Fulfilling commitments made to the Departments of Microbiology and Immunology with respect to space and personnel.
15. Clarifying the mandates for the Banting and Best Department of Medical Research and the Charles H. Best Professor of Medical Research.
16. Strengthening Continuing Education for health professionals, including further development of the potential of telemedicine.
17. Examining the administrative structure of Radiation Therapy, Neurology, Speech Pathology, Occupational and Environment Health, Art as Applied to Medicine, and Emergency Medicine.
18. Securing funds to assure continuation of the policy of mounting external searches for new department chairmen and hospital chiefs.
19. Establishing a regular Faculty newsletter as part of a broader effort to improve Faculty communication and relations with students, teachers and alumni.
20. Preparing Faculty positions on current issues and those that may arise during the next few years including:
    - research partnerships with industry,
    - reduction of undergraduate medical student admissions,
    - the role of the Faculty with respect to health care delivery in Toronto,
    - the recommendations of the Bovey Commission on the Ontario University system,
    - training of physician extenders, or expanded responsibilities for other health professions,

- possible job actions by UTFA or the OMA, and
- the impact of new technologies on teaching and research.

It will be evident that the plans and priorities outlined in this section relate to the Faculty mission and the strategic challenge of striving for parity with the best medical schools in the world. As I have stressed already, the specific points made in this section are not the only problems and opportunities we need to address. We know too that changing (and often unpredictable) circumstances will dictate a change of plans. Nevertheless, the points outlined here constitute a work list for the next three years that will engage most of us.

5. ORGANIZATION OF THE DEAN'S OFFICE (1984-87)

A final step in preparing for the future is a further reorganization of the Dean's office to improve its operations. As of July 1, 1984, the position of Assistant Dean — Undergraduate Medical Curriculum will be eliminated and the Student Affairs portfolio will become an Assistant Deanship.

A new Associate Dean position will be created, for a period of three years (to June 30, 1987). This will be the Associate Dean — Neurosciences Development.

Finally, the position of Faculty Development Coordinator will become a full-time commitment to the Dean's office, responsible for planning and development activities as well as support to various Faculty activities.

V. SUMMARY AND CONCLUSION

This Faculty of Medicine, one of Canada's oldest and its largest, has assumed a position of national leadership in most areas of our field. This imposes upon us obligations and standards higher than those dictated by our teaching and local service responsibilities. It requires that we insist upon excellence at the international level as a benchmark against which to judge our activities, and it calls for exacting standards with respect to the appointment of new staff and the admission of students.

Fortunately, the Faculty's performance in recent years supports the conclusion that our mission is attainable.

1. The undergraduate medical program, reviewed last year by the LCME/CACMS, received full accreditation for the maximum of seven years, and considerable praise.

2. The postgraduate medical specialty programs also were reviewed last year by the Royal College of Physicians and Surgeons. Forty-eight of these were given full approval, and only three were approved contingent upon modification. The overall quality of these programs was thought to be high and "some programs, the best in Canada, have a well-deserved international recognition."[8] The popularity of these programs has resulted in considerable growth of 16% during the past five years (from 1517 enrolled in 1978 to 1761 in 1983).

3. The graduate programs, a joint responsibility of the Faculty and the School of Graduate Studies, have also been reviewed favorably by the Ontario Council of Graduate Studies. These programs have undergone massive expansion; during the past five years, PhD enrolment has grown by 57%, MSc enrolment by 45%, and full-time MHSc enrolment has increased by almost 100%. This represents a total increase from 583 students in 1979 to 833 students in 1983.

4. The undergraduate programs in Physical Therapy, Occupational Therapy and Art as Applied to Medicine and the graduate program in Speech Pathology have continued to attract first rate students, though they have suffered from budgetary erosion and from not having been accorded high priority in the past.

5. The Faculty's research programs, mounted on the University campus and in the teaching hospitals, constitute Canada's largest single concentration of biomedical investigation. These programs are attracting well over $50 million of external grant support. Some of our investigators are among the world's leaders in their fields.

6. The academic leadership of the Faculty has been renewed. During the past three years, seventeen new department chairmen and four new directors of major units have been appointed, as well as a large number of new division heads, hospital department chiefs, and clinical and basic scientists.

These accomplishments were possible despite eight successive years of base budget cuts. During seven of these years, our budget cut has been disproportionately higher than those of the University's other large faculties, and this has forced us to rely increasingly upon funds earned or donated by our own staff.

In the present academic year, we are earning or recovering 44% of our operating budget outside of the University's budget allocation. This percentage has been increasing steadily in recent years. University-derived funds this year supported only 40% of our 1000 full-time equivalent academic staff, and an even smaller proportion of our 300 administrative support staff.

There is every reason to be confident about the Faculty's future and its prospects for discharging its mission. Though the times have been difficult, it has been highly rewarding for me, as Dean, to be interacting with a talented, highly committed group of colleagues. I look forward to the remainder of my term.

Frederick H. Lowy
June 1984

REFERENCES

1. Faculty of Medicine, *Report of the Independent Planning Committee*, October 1969.
2. Faculty of Medicine, *Report of the Institutional Self-Study Steering Committee*, 1977.
3. Liaison Committee on Medical Education, *Report of the Survey of the University of Toronto Faculty of Medicine*, March, 1983.
4. Wallis, C. "Med school, heal thyself" *Time*, May 23, 1983, 54-55. Quoted by N. D. Anderson, "The MCAT Malady," *New England Journal of Medicine*, Vol. 310, No. 6, p. 396, 1984.
5. The Royal College of Physicians and Surgeons of Canada, *Report of the On-site Survey of Specialty Training Programs, University of Toronto and Affiliated Teaching Hospitals*, Vol. 1, p. 10, March, 1983.
6. LCME *Report*.
7. Harris, Robin, University Historian, Personal Communication, May 1983.
8. Royal College *Report*.

APPENDIX: DEPARTMENT CHAIRMEN - 1980-84

Anaesthesia:	A.A. Scott (1977-)
Anatomy:	K.L. Moore (1976-)
Art as Applied to Medicine:	N. Joy (1973-)
BBDMR:	D.H. MacLennan (1980-)
Behavioral Science:	S. Griew (1980-81)
	M. J. Kelner (Acting, 1981-83)
	Q. Rae-Grant (1984-)
Biochemistry:	K. J. Dorrington (1980-82)
	M. A. Packham (Acting, 1982-83)
	H. Schachter (1984-)
Clinical Biochemistry:	D. M. Goldberg
Family and Community Medicine:	F. B. Fallis (1980-82)
	W. H. Palmer (1982-)
Health Administration:	E. Vayda (1980-81)
	J. E. F. Hastings (Acting, 1981-82)
	T. Goldberg (1983-)
Medical Biophysics:	G. F. Whitmore (1980-81)
	R. A. Phillips (1981-)
Medical Genetics:	P. D. Sadowski (Acting, 1980-81)
	J. D. Friesen (1981-)
Medical Microbiology:	L. P. Spence (Acting, 1980-82)
Microbiology and Parasitology:	R. Sheinin (1980-81)
	L. W. MacPherson (Acting, 1981-82)
Microbiology (combined)*:*	L.P. Spence (1983-)
Medicine:	C. H. Hollenberg (1980-81)
	G. N. Burrow (1981-)
Nutritional Sciences:	G. H. Beaton (1980-81)
	G. H. Anderson (1981-)
Obstetrics and Gynecology:	J. L. Harkins (1980-82)
	W. J. Hannah (1982-)
Ophthalmology:	C. McCulloch (1980-82)
	C. B. Mortimer (1982-)
Otolaryngology:	D. P. Bryce (1980-82)
	P. W. Alberti (1982-)
Paediatrics:	D.H. Carver (1976-)
Pathology:	E. Farber (1975-)
Pharmacology:	P. Seeman (1977-)
Physiology:	D. W. Clarke (Acting, 1980-81)
	H. L. Atwood (1981-)
Preventive Medicine and Biostatistics:	M.J. Ashley (1981-)
Psychiatry:	V.M. Rakoff (1980-)
Radiology:	E.L. Lansdown (1974-)
Rehabilitation Medicine:	J.S. Crawford (1980-83)
	J.T. Marotta (Acting, 1983-84)
Surgery:	D. R. Wilson (1980-82)
	B. Langer (1982-)
Banting and Best Diabetes Centre:	C. H. Hollenberg (1981-)
Institute of Biomedical Engineering:	R. S. Cobbold (1980-83)
	W. Zingg (1983-)
Institute of Immunology:	B. Cinader (1980-81)
	A. Zimmerman (1981-82)
	B. J. Underdown (1982-83)
	R. G. Miller (1983-84)
Institute of Medical Science:	E. A. McCulloch (1980-81)
	D. A. K. Roncari (1981-83)
	A. Angel (1983-)
Hannah Chair of the History of Medicine:	P.M.H. Mazumdar (1976-)
Playfair Neuroscience Unit:	W.G. Tatton (1978-)
Occupational & Environmental Health Unit:	G. J. Stopps (Acting, 1980-81)
	J. R. Nethercott (1981-)

Design: Instructional Media Services, University of Toronto, 1984